



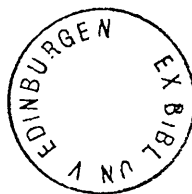
THE UNIVERSITY *of* EDINBURGH

This thesis has been submitted in fulfilment of the requirements for a postgraduate degree (e.g. PhD, MPhil, DClínPsychol) at the University of Edinburgh. Please note the following terms and conditions of use:

- This work is protected by copyright and other intellectual property rights, which are retained by the thesis author, unless otherwise stated.
- A copy can be downloaded for personal non-commercial research or study, without prior permission or charge.
- This thesis cannot be reproduced or quoted extensively from without first obtaining permission in writing from the author.
- The content must not be changed in any way or sold commercially in any format or medium without the formal permission of the author.
- When referring to this work, full bibliographic details including the author, title, awarding institution and date of the thesis must be given.

Student nurses' accounts of their work and training :
a qualitative analysis

Kath M. Melia



Doctor of Philosophy
University of Edinburgh

1981

Acknowledgements

Without the co-operation of the student nurses this thesis could never have been written. I am indebted to them, not only for the data, but for their enthusiastic approach to the study and the warmth which they showed towards me. They made the fieldwork enjoyable and I am grateful. My thanks also go to the staff of the colleges of nursing for opening their doors to me and making me feel so welcome.

This thesis is the development of work supported by the Scottish Home and Health Department and undertaken in the Nursing Studies Research Unit, University of Edinburgh. I was fortunate to have the Director of the Unit, Dr Lisbeth Hockey, as academic supervisor. I offer my thanks for her constant guidance and support and for her faith in the study in its early days.

To Dr Dorothy Baker, University of Manchester, also academic supervisor, I owe a great debt. For her endless goodwill, enthusiastic discussion, voluminous comments upon drafts and, not least, for coping with the 200 miles which lay between us, my sincere thanks.

My thanks to Dr Robert Dingwall, whose advice in the early stages of analysis greatly eased the production of this thesis. His comments upon subsequent drafts were generously given and gratefully received.

Thanks are also due to Dr Hamish MacLeod for his good humoured assistance with the computing and statistical element of the work.

In various ways a number of friends and colleagues have helped this thesis to fruition, my thanks to them; especially to Trevor Jones for timely discussions of qualitative methodology in the early days.

Finally, my thanks go to Valerie Chuter, both for typing this thesis and for her triumph over my handwriting.

This thesis is dedicated to my father; it is my regret that he did not live to see it, for, he would have been intrigued.

Abstract

This thesis reports a study which attempted to explore how a group of student nurses perceived their experience of being learners of nursing. In order to obtain the students' accounts of this experience, a qualitative methodological approach was adopted, drawing upon the work of Glaser and Strauss (1967) on the generation of 'grounded theory'. The fieldwork took the form of informal interviews with forty student nurses. Certain predetermined topics provided the overall direction of the fieldwork; the students were encouraged to develop these and to raise any others which they thought to be pertinent to nursing.

The interviews were tape recorded and their analysis resulted in the emergence of six conceptual categories which served as a framework for the presentation of the substantive issues raised by the students. Three major themes are taken up from the data, these are: the student experience as a preparation for staff nurse work, the functional interchangeability of the student and the nursing auxiliary and, the concept of medical dominance.

This study sheds some light on the process of occupational socialisation in nursing and examines the question of profession and professionalisation in relation to nursing. The concluding discussion moves beyond the data and examines the occupational structure of nursing; this is relevant to the study because the students were preparing to become part of that structure. Moreover the occupational structure has implications for the recruitment of students and the organisation of their training. Four sub-groups within nursing are identified, namely: 'new managers', 'new professionals', 'rank and file' and 'academic professionalisers'. A speculative discourse upon how these groups might articulate with each other, in order to produce an efficient nursing service, is offered and areas for further study are suggested.

TABLE OF CONTENTS

| | <u>page</u> |
|--|-------------|
| Introduction | 1 |
| PART ONE | 5 |
| Chapter 1 Background to the study | 6 |
| Introduction | 7 |
| Occupational socialisation | 9 |
| Chapter 2 The qualitative approach | 20 |
| Qualitative and quantitative approaches to reality | 22 |
| Development of sociological theories | 25 |
| 'Positivism' and 'verstehen' considered | 28 |
| Uses of theory | 34 |
| Generation of 'grounded theory' | 37 |
| Why generate 'grounded theory'? | 43 |
| Chapter 3 Methodological issues and fieldwork | 45 |
| 1. Introduction | 46 |
| Symbolic interactionism | 49 |
| 2. The fieldwork literature | 55 |
| Recording the data | 66 |
| 3. Towards the interview - early days | 66 |
| Early interviews | 70 |
| 4. About the students | 76 |
| The volunteers | 81 |
| 5. Doing fieldwork | 85 |
| Approaching the students | 86 |
| The interviews | 88 |
| PART TWO | 95 |
| Chapter 4 Strategies for analysis | 96 |
| Approaches to qualitative data | 98 |
| Analytic induction | 102 |
| Constant comparative method | 105 |
| 'Theoretical notes' | 107 |
| Analysis tactics | 110 |
| Chapter 5 'Learning and working' | 115 |
| College versus ward | 117 |
| The clinical teacher | 122 |
| Students and auxiliaries | 125 |
| 'Practice' versus 'theory' | 131 |
| Why theory? | 135 |
| Student or worker? | 138 |
| Assessment and counselling | 144 |
| Discussion | 147 |

| | <u>page</u> |
|---|-------------|
| Chapter 6 | |
| 'Getting the work done' | 152 |
| Running the ward | 154 |
| Styles of management on the ward | 157 |
| Management and non-management | 161 |
| Alternative organisational forms | 165 |
| Routines | 170 |
| Discussion | 175 |
| Chapter 7 | |
| 'Learning the rules' | 181 |
| The students' notion of nurse | 183 |
| Occupational socialisation | 186 |
| 'Unwritten rules' | 190 |
| Talking versus working | 193 |
| 'Looking busy' | 196 |
| Discussion | 198 |
| Chapter 8 | |
| 'Nursing in the dark' | 204 |
| How much can the student say? | 207 |
| Evasion | 213 |
| Uncertainty | 218 |
| Establishing a 'professional' relationship | 224 |
| Discussion | 227 |
| Chapter 9 | |
| 'Just passing through' | 229 |
| 'Getting on' and 'getting through' | 233 |
| Transience as utility | 234 |
| Students as a labour pool | 238 |
| Organisational slots and stereotyped students | 242 |
| Settling down | 246 |
| Students' view of 'nursing work' | 251 |
| Passing out - staff nurse work | 255 |
| Summary | 260 |
| Chapter 10 | |
| Doing nursing and being professional | 262 |
| Doing nursing | 263 |
| Medical dominance | 272 |
| A note on 'profession' | 279 |
| Students' usage of profession | 287 |
| Discussion | 295 |
| Chapter 11 | |
| Concluding analysis | 301 |
| 'Fitting in' | 303 |
| 1. The student experience | 305 |
| Socialisation | 306 |
| Student to staff nurse | 310 |
| ... and after registration? | 316 |
| 2. Students and auxiliaries | 320 |
| Interchangeability - students and auxiliaries | 321 |
| The question of profession | 324 |
| 'Professionalism', 'managerialism' and ...? | 326 |
| 3. Medical dominance | 335 |
| 'Fitting in' to nursing ...? | 339 |
| Conflicting interests | 342 |
| Towards a reconciliation of interests | 346 |

| | <u>page</u> |
|----------------|-------------|
| Appendix I | 360 |
| Appendix II | 363 |
| Appendix III | 366 |
| Table 1 | 80 |
| Tables 2 and 3 | 83 |
| Table 4 | 84 |

"... the answer to the question 'What does this social world mean for me the observer?' requires as a prerequisite the answering of the quite different questions 'What does the social world mean for the observed actor within this world and what did he mean by his acting within it?..."

(Schutz 1964:7) (1)

-
1. Schutz, A (1964) Collected papers II : studies in social theory.
Martinus Nijhoff : The Hague

INTRODUCTION

This thesis is concerned with student nurses' experience of work both in the college of nursing and on hospital wards. The study evolved from a larger work pertaining to the organisation of nursing at ward level (Moult, Hockey, Melia 1978). The researcher's part in that study included some non-participant observational work, which attempted to relate the style of ward organisation to the amount of time which student nurses spent talking with patients. One of the main findings ⁽¹⁾ of the observational study was that, whatever the organisational style of the ward, the student nurses spent little time simply talking with the patients.

It was with this finding in mind that the researcher became interested in discovering more about student nurses' thoughts on nursing. Rather than continue with an observational approach to the study, it was decided to adopt a more direct line of enquiry and to elicit the students' views on nursing by means of the informal interview. It should also be noted that the original interest in the time student nurses devote to talking with patients was grounded in the researcher's own conception of nursing. This perspective, it was thought, should not be imposed on the interviews with the students. The fieldwork, therefore, laid no more emphasis on communication than upon any other aspect of nursing work.

The underlying premise of this change in methodological tactic was that nurses' actions, particularly student nurses' actions, should not be taken at face value. There are other factors, social contextual factors involved which might affect what a nurse does.

(1) For a further discussion see Appendix I.

These factors cannot always be observed and, moreover, they must be appreciated from the point of view of the actor. It seemed a logical progression, therefore, to move from non-participant observation of the students to a research style which allowed some insights into their activities and their construction of nursing. In other words, in order to provide some explanation of the finding that student nurses spent little time talking with patients, it was thought that it might be more appropriate to ask the students for their views on nursing rather than simply to observe them and draw inferences from those observations.

The emergent study, therefore, has moved some considerable way from the original work, which concerned itself much more with styles of ward organisation and nurse-patient communication. Once these specific concerns had been subsumed within a more generalised interest in discovering how student nurses viewed their world, the scope of the study widened. The result is an analysis of student nurses' accounts of their work and training.

The thesis is organised in two parts, the first deals with the background to the study and the methodological issues, the second with the data and their analysis. The first chapter sets the study into context and examines some of the seminal work on occupational socialisation. The second and third chapters offer a general discussion of qualitative methods and a description of the fieldwork. The fourth chapter describes, procedurally, the analysis, this chapter serves as an introduction to chapters five to ten; these are concerned with the conceptual categories and, thereby, the data and

their interpretation. The last chapter draws out three main issues from the categories and then speculates beyond the data to outline some of the wider issues which the study raises: issues which concern the occupational structure of nursing.

PART ONE

CHAPTER 1

Background to the study

Introduction

Nursing and nurses have for some time caught the imagination of researchers; thus, the study of student nurses is by no means a new enterprise. As evidenced by Macguire (1969), among the central topics of concern of both the nursing profession and outside investigators, has been the recruitment and subsequent retention of student and pupil nurses.

Macguire's review dates from 1940 and includes more than sixty studies concerned with nurse 'wastage'. She includes studies which, even if not directly related to 'wastage', shed some light on the overall question of nursing labour. The studies are grouped under the general headings: recruitment and selection, training and withdrawal, experimental training schemes, sickness and absence, the qualified nurse and the hospital environment. Macguire (1969:127) stated that:

'There is a great need for continuing research in the general field of the training and education of nurses. There are changes in the pool of potential recruits, changes in the concepts of medical and nursing care, changes in the programmes of nursing training, changes in the demands made by hospitals and local authorities for qualified nursing staff, which means that information must be available on the current situation of learners if plans are to be prepared in advance for the future'.

The general tenor of Macguire's recommendations for further research is revealed in her remarks concerning future planning: her suggestions focus upon recruitment, training and wastage. In line with these recommendations many studies undertaken since Macguire's review have tended to concentrate upon student nurse attrition and various aspects of nurse training (Birch 1975, Bendall 1975, Pomeranz 1973,

Alexander 1980, Dodd 1973). With the exception of Dodd's work, the students' opinions were sought in these studies, for the most part, in relation to the specific questions of recruitment and training. The studies concerned with training include evaluation of experimental and variant approaches to nurse training and thus, draw upon research methods developed in education.

Hockey (1976) undertook a survey, which had as its substantive focus 'the problems experienced and created by female nurses'. With this study Hockey provides a description of the qualified members of the nursing work-force and gives some insights into 'women as nurses and nurses as women'. It seems, however, that student nurses have not been the subject of such an investigation which seeks to discover their views of nursing. They have been studied in terms of recruitment, training and attrition rather than as individuals engaged in becoming nurses. There have also been methodological leanings towards survey analysis, the measurements of psychology and the strategies of educational research. Whilst these studies undoubtedly have their place, they tell us little of what it is like to be a student nurse; the research offerings of the sociologists have more promise in this direction.

Sociologists' interest in nursing has, to an extent, in its focus mirrored one of their main reasons for studying medicine, namely, for its contribution to the sociology of occupations. When sociologists have written about nursing they have, in the main, been concerned with nurses as the substantive focus of their study of occupational socialisation. This chapter, therefore, concentrates upon the literature of occupational socialisation in medicine and nursing.

Occupational socialisation

A focus on medicine has furnished the sociology of occupations with some of the seminal works on professional socialisation (Merton et al 1957, Becker et al 1961, Bloom 1971). Two of these studies, which might be regarded as 'classics', are discussed here as an introduction to the socialisation studies which concern nursing.

Merton et al (1957), in a collection of papers reporting separate studies, present a functionalist approach to their study of medical education. Merton and his colleagues focus upon the acquisition of the professional role by the students, and consider the medical school as the socialising agency. This view of occupational socialisation is perhaps best summarised in the caricature supplied by Olesen and Whittaker (1968:5).

'Once the educational system has formally started work on the student, his empty head is filled with values, behaviors, and viewpoints of the profession, the knowledge being perfect and complete by the time of graduation. To achieve this state of grace, the student has smoothly moved ever away from the unholy posture of layman, upward to the sanctified status of the professional, being divested of worldly care and attributes along the way. The result: "the true professional", "the finished product", "the outcome of the system"...'

In the functionalist's view, the acquisition of values and attitudes of the medical profession is seen in terms of apprenticeship. Their very title, the student-physician, suggests a doctor's apprentice rather than a student role. Huntingdon (1957) found that:

'as students move through medical school they tend to develop an image of themselves as doctors rather than as merely students, especially in their clinical years when they have substantial contact with patients'
(in Merton et al 1957:186)

The functionalist approach to professional socialisation, then, entails a focus of study upon the students' experiences within the context of the institutionalised body which nurtures and keeps the profession's knowledge and culture. In Merton's words:

'medical students are engaged in learning the professional role of the physician by so combining its component knowledge and skills, attitudes and values as to be motivated and to be able to perform this role in a professionally and socially acceptable fashion'. (Merton et al 1957:41)

Merton et al (1957:7) demonstrate their confidence in the medical school as the socialising agency when they say:

'Medical schools (thus) become the guardians of the values basic to the effective practice of medicine ... It is their function to transmit the culture of medicine and to advance that culture. It is their task to shape the novice into the effective practitioner of medicine, to give him the best available knowledge and skills, and to provide him with a professional identity so that he comes to think, act and feel like a physician. It is their problem to enable the medical man to live up to the expectations of the professional role long after he has left the sustaining value-environment provided by the medical school'.

Clearly, the interrelationship between the medical school and the wider profession of medicine is assumed in the functionalist approach to professional socialisation.

The second 'classic', Becker et al's (1961) 'Boys in White', represents a challenge to the functionalist approach to professional socialisation. Becker et al take an interactionist perspective and focus upon the actual 'work' of the members of the occupation, rather than their 'professional' claims and rhetoric. Thus, a study of professional socialisation will focus upon the students rather than the

school, or the professional role.

Central to Becker et al's work is the notion of a 'student culture' which develops as a distinctive sub-culture within the medical school. They use 'culture' in an anthropological sense to mean

'a body of ideas and practises considered to support each other and expected of each other by members of same group of people' (Becker et al 1961:436).

The perspectives developed by the students in order to 'get through' medical school, taken together form the student-culture.

'They developed ways of acting, studying and working which made it possible for them to achieve the goal in the situation they had defined. Similarly, the students in their clinical years saw the situation as one in which the goal of learning what was necessary for the practice of medicine might be interfered with by the structure of the hospital and by the necessity of making a good impression on the faculty. As they came into contact with clinical medicine they developed new goals that were more specific than those that they had had before' (Becker et al 1961:436).

Becker et al, then, focused their attention upon how the student got through medical school, how they 'made out'. Their analysis is, therefore, much more to do with how the student negotiates his way through the professional socialisation and, as such, plays a vital part in it. As Becker et al put it:

'He (the student) adapts his behaviour to the situation as he sees it, ignoring possible lines of action which appear pre-ordained to fail or unworkable, discarding those which may cause conflict - in short, choosing the action which seems reasonable and expedient' (Becker et al 1961:442).

The major difference between the approaches discussed centres upon the position of the student within the hierarchy. Merton and his colleagues saw the student in terms of 'junior colleague' whereas

Becker et al saw him merely as a student, indeed they point out at length that:

'students do not take on a professional role while they are students, largely because the system they operate in does not allow them to do so. They are not doctors and the recurring experiences of being denied responsibility make it perfectly clear to them that they are not' (Becker et al 1961:420)

In the light of this distinction, the importance of the different emphasis upon medical school, in Merton's work, as socialising agency and the student culture, in Becker's, becomes clear.

Simpson (1980) in an introductory note on professional socialisation sums up the difference between the two approaches when she says:

'The induction ⁽¹⁾ model pictures a profession as a solidary system with social control arising from shared outlooks and mutual interests. The professional school is conceived as both a part and an agency of the profession, charged with inducting students into it in a way that ensures its continuous structure and function. Studies of professional education employing the induction approach are grounded on the supposition that students learn norms and values and that as practitioners these norms and values guide them to act in ways consistent with the institutionalised role of the occupation. The reaction model, in contrast, conceives social control as a matter of power. Behavioural options increase power; contingencies on behaviour reduce it ... The reaction model sees learning to behave in a status as occurring after, not before, the individual occupies the status. Its exponents do not consider adequate or useful the assumption of the induction model that a professional product is produced during professional education' (Simpson 1980:10-11).

Simpson (1980) does not consider the approaches of Merton et al and Becker et al to be opposing, rather she suggests they address different

(1) Simpson uses the terms 'induction' and 'reaction' which, for the purposes of this discussion are synonymous with 'functionalist' and 'interactionist' respectively.

issues. Further, she says that both works are crucial in the study of professional socialisation and so attempted to bring the contributions of both approaches to bear on her longitudinal study of student nurse socialisation. Simpson distinguished three dimensions of occupational socialisation, namely, 'education', 'orientations', and 'relatedness to the occupation'. The study was then designed to:

'view socialization as a complex set of dimensions to examine the extent of their directionality and persistence over time without specifying in advance what those must be, and to observe the varied conditions and influences underlying the development and differentiation of dimensions of socialisation' (Simpson 1980:47-48).

Simpson's work is not dealt with extensively here as its main thrust lies not in empirical findings but in "theoretical efforts to extend research on occupational socialisation" (Simpson 1980:56). It is included in this brief review because it furnishes an attempt to combine aspects of the two major perspectives on occupational socialisation which have already been discussed.

The main aim of the study was to develop a synthetic model of socialisation. Simpson (1980:226) argues that the research shows the importance of avoiding a static unidimensional or unidirectional conception of a complex processual phenomenon composed of interrelated processes. To sum up Simpson's work in her own words:

'Our study has attempted to clarify the concept of occupational socialisation by specifying its multidimensionality. We have shown that it involves learning skills and knowledge of the occupation, developing orientations to occupational roles and to a place in the occupation, and relating the person to the occupation. Each dimension consists of distinct processes, and these were developed by different conditions' (Simpson 1980:225).

Whilst it demonstrated the potential of a multidimensional approach to the study of occupational socialisation, Simpson's study gives little insight into the students' experience of becoming nurses. Davis (1975) perhaps goes some way towards this in his paper 'Professional socialisation as subjective experience: the process of doctrinal conversion among student nurses'. Davis owns that the paper was stimulated by the writings of Everett Hughes, ⁽¹⁾ which called for studies of such transitions from layman's status to that of the professional.

In this work Davis identifies six stages through which the students move in discarding their lay imagery of nursing in favour of 'institutionally approved' imagery of the professional nurse. These stages, it must be noted, are analytic devices rather than temporal entities; they are: initial innocence, labelled recognition of incongruity, 'psyching out', role simulation, provisional internalisation and stable internalisation. These stages describe how the students move from a lay conception of nursing to a realisation that "nursing school is not what we expected", and then direct their attention towards discovering how best to satisfy the tutors, to try out and eventually internalise the perspectives of professional nurses.

As Davis puts it:

'Despite occasional misgivings which hark back to the initial lay imagery, the self image of students is by now rather firmly that of professional nurses of a particular doctrinal persuasion'.

(1) in Men and their Work (1958:119-20).

Davis suggests that his analysis of the subjective experience of becoming a nurse confirms Hughes' (1958) seminal observation that learning a professional role is like

'passing through a mirror ... (to create) ...
the sense of seeing the world in reverse'
(Davis' rendering of Hughes 1958:119-20)

Davis goes on to say that:

'it remains for sociology to follow the lead of Hughes and to generate models of professional socialisation that are far more faithful to this picture of thinking, feeling, ever-responding and calculating human actors groping their way through the ambiguities posed by the confluence of their lived pasts and imagined futures; models, in other words, which in their sociological richness and complexity transcend the dominant one available today - that of neutral, receptive vessels into whom knowledgeable, expert members of a profession pour approved skills, attitudes and values' (Davis, in Cox and Mead 1975:130).

The abandonment of the "empty vessels to be filled" view of occupational socialisation is the central concern of Olesen and Whittaker's (1968) important work on student nurses. This work takes what might broadly be termed an interactionist approach, though the authors were influenced by existential phenomenology. The authors' description of the 'Silent Dialogue' furnishes both a most sensitive approach to occupational socialisation and a rationale for abandoning the empty vessel approach.

'Embedded in the frequently banal, sometimes dreary, often uninteresting world of everyday living, professional socialization was of the commonplace. In the mundane, not in the abstract or exalted, occurred the minute starts and stops, the bits of progress and backsliding, the moments of reluctant acquisition of a new self and the tenacious relinquishing of the old; the flush of pride and elation when telling a fellow student about a good evaluation or listening silently and painfully when

being told of someone else's good marks; the feeling of relief that one had not been the object of group laughter in conference; the sense of anxiety when learning from a classmate that yet another student had married or become engaged; the right look at the right time when discussing the patient with the instructor. These matters constitute the silent dialogue wherein are fused person, situation and institution. Therein lies the heart of professional socialization' (Olesen and Whittaker 1968:297).

Olesen and Whittaker state that their study is 'about becoming'. In many ways their work reflects the findings of Boys in White (Becker et al). Olesen and Whittaker (1968) describe 'studentmanship' which was the term they used for the students' strategies for success and survival.

'Whereas studentmanship eased the class through school by providing a readily comprehended set of understandings about faculty and the school, this same set of norms proved to be as stringent for the students as was the faculty. Student conformity to the norms of student culture with respect to meeting their well-ingrained competitiveness at the same time they bowed to the demands of other norms for striving was no less complete than the formal role subordination to faculty. In this sense the norms of student culture constituted an added set of difficulties that sharpened awareness, for presentations of self frequently had to be made for two audiences, faculty and peers, whose rewards and punishments were on the one hand official success or failure and on the other the esteem or derogation of classmates' (Olesen and Whittaker 1968:292).

'Studentmanship' is, then, similar to the 'student culture' which Becker et al (1961) described among the medical students in Kansas. Both constructs describe how students develop perspectives on their day to day work which allow them to 'get through' and achieve their long-term goals. Olesen and Whittaker's (1968:300) work is best described by their own final remarks on the study:

'the workable model for study of students in the professions is the model of the student as an active, choice-making factor in his own socialization'.

On the evidence of the American literature it would appear that a study of the socialisation of student nurses in Britain might repay investigation. Studies of this kind have not been mounted in the area of general nursing. However, the work of Towell (1975) and Dingwall (1974, 1977) are mentioned here as examples of a sociological approach to the study of nursing. The substantive areas involved in these works were, psychiatric nursing and health visiting.

Towell set out to examine, from a sociological perspective, 'the roles of nurses and the nature of their relationship with patients on the wards of a psychiatric hospital'. His work takes the form of a case study of one hospital where he carried out fieldwork in three wards. Whilst Towell's study was not explicitly one of socialisation, he did focus upon the student nurse in his study of the nursing staff sub-culture. The vocabulary of terms available for categorising patients, the perspectives used for interpreting patient behaviour and the concern nurses derive from their social role together form a set of understandings which are the nursing sub-culture. Towell was interested in examining how these understandings were acquired by student nurses who were new to the wards he studied. During his fieldwork Towell joined a six week induction course for a new group of students and thus, shared their initial experiences of the hospital. Towell's work, whilst clearly of interest to those concerned with psychiatric nursing, demonstrates on a wider front the insights

which can be gained from study of student nurses' work. Towell's interest in "the shared 'social worlds' of nurses on the wards" places him in the interactionist methodological camp.

The closest to the realisation of a study of occupational socialisation in nursing is to be found in the work of Dingwall (1974). He undertook a study of the training of health visitors using fieldwork methods. In this study Dingwall abandoned the notion of socialisation in favour of 'aculturation'. Following Olesen and Whittaker (1968) he argues that the term socialisation is too closely bound up with the ideas of enculturation, which involve the notion of a passive absorption of values, attitudes and perspectives. Dingwall (1974:39) contends that:

'the enculturation model sees actors as passive, moving in a smooth, unproblematic, unilinear path towards passing out as completely finished products'.

On the other hand, Dingwall states:

'the aculturation model sees actors as working on their world to make sense of it, and their passage as uneven, continually problematic, individually paced and incomplete'.

Thus, he suggests, that socialisation is so clearly associated with aculturation that it is misleading; in describing his study Dingwall states:

'Consequently the study is not about socialisation. It is about the social organisation of the acquisition of competent membership' (Dingwall 1974:40).

Dingwall's work provides an account of how the students achieved their goal, namely to become health visitors. Dingwall's work is essentially an ethnography which draws upon the work of ethnomethodologists and results in an account of the social organisation of health visiting training and a discussion of how the students 'accomplish profession'.

No further discussion of this work is offered here as it is drawn upon and explained, as appropriate, throughout the thesis.

British nursing might still be said to stand in need of a study of the socialisation of its students. This thesis attempts to go some small way towards meeting this need. To mount a longitudinal study of the socialisation of student nurses would be both a lengthy and costly exercise. This study, instead, takes a detailed look at how the students, themselves, describe their world. Whilst not claiming to be a socialisation study, this work should provide some insights into what it is like to 'become' a nurse. This thesis, then, seeks to explore the student view of nursing through an analysis of students' accounts of their experiences.

CHAPTER 2

The qualitative approach

There will inevitably be more than one way of approaching most research problems; the present study was no exception. The decision to use a qualitative approach was taken because the researcher felt that there was a need to get the student nurses to express their ideas about nursing in a spontaneous, essentially non-directed way. In this attempt to get close to the data it was thought that the uniformity, which a more structured approach would afford, could be sacrificed in the pursuit of qualitative data. This chapter is, then, devoted to an examination of the qualitative approach to social science research. It deals, in general terms, with qualitative methods and in particular with the notion of 'grounded theory' as propounded by Glaser and Strauss (1967).

In sociology there is a long standing divide between the qualitative and the quantitative approaches to the collection and analysis of data. The quantitative approach, which takes its lead from the physical and natural sciences, is propounded by those who favour a systematic and 'objective' way of gathering 'facts' about a subject and then, by means of rigorous analysis, arriving at conclusions which it is argued are upheld by the data in much the same way as are the conclusions of the natural and physical scientists. Reliability and validity are two major concerns of the sociologists adopting a quantitative approach. The qualitative methodologists, on the other hand, do not place so much emphasis on the idea of predicting human behaviour, rather they favour the understanding of the behaviour in the tradition described by Weber as 'verstehen'.

Qualitative and Quantitative approaches to reality

There have been swings in the popularity of the qualitative and quantitative methods of social research. The Chicago studies of the 1920s and 1930s employed methods of data collection which yielded rich descriptions of different groups of the population of the city of Chicago (Shaw 1930, 1931, Thrasher 1928, Zorbaugh 1929). These studies were undertaken in the spirit of experiment, with Chicago as the 'laboratory'. The intention of the leaders of the sociologists at Chicago was to present sociology as an experimental science (Park and Burgess 1921). They encouraged the researchers to study the principal forms of human interaction: competition, conflict, accommodation and assimilation in their diverse historical manifestations. These studies were to be undertaken with an approach similar to that of the natural scientist without letting moral concerns or practical reforms impede the study (Goudsblom 1977). Survey research developed between the two World Wars and emerged after the Second World War as the most popular sociological research method for a time (cf. Stouffer et al. 1949). The coincidence of the emergence of survey techniques and the development of computers led to a great deal of survey research and reinforced the popularity of the method.

It should be axiomatic that the choice of method in social research is dictated by the needs of the study. However, this simple approach to the choice has been cluttered by the desire of many sociologists to acquire 'respectability' by using the 'scientific' model in their research design. The availability of sophisticated techniques in handling data by computer has made the move towards the quantitative method an even more attractive one. Filstead (1970:5) goes so far as to say that:

There will inevitably be more than one way of approaching most research problems; the present study was no exception. The decision to use a qualitative approach was taken because the researcher felt that there was a need to get the student nurses to express their ideas about nursing in a spontaneous, essentially non-directed way. In this attempt to get close to the data it was thought that the uniformity, which a more structured approach would afford, could be sacrificed in the pursuit of qualitative data. This chapter is, then, devoted to an examination of the qualitative approach to social science research. It deals, in general terms, with qualitative methods and in particular with the notion of 'grounded theory' as propounded by Glaser and Strauss (1967).

In sociology there is a long standing divide between the qualitative and the quantitative approaches to the collection and analysis of data. The quantitative approach, which takes its lead from the physical and natural sciences, is propounded by those who favour a systematic and 'objective' way of gathering 'facts' about a subject and then, by means of rigorous analysis, arriving at conclusions which it is argued are upheld by the data in much the same way as are the conclusions of the natural and physical scientists. Reliability and validity are two major concerns of the sociologists adopting a quantitative approach. The qualitative methodologists, on the other hand, do not place so much emphasis on the idea of predicting human behaviour, rather they favour the understanding of the behaviour in the tradition described by Weber as 'verstehen'.

'Most sociologists do not deny the immense heuristic value of qualitative data, to do so would indicate poor professional judgment. However, very few recognise qualitative methodology as a legitimate source of either data collection or theory construction'.

There is in fact a tendency to consider a qualitative method to be of use only in the exploratory phases of a study, in order to open up substantive areas which must then be investigated to obtain the 'facts' by a 'respectable' quantitative method. The qualitative method does indeed have its place in the exploratory phases of a research project, but can also yield useful data in its own right.

Nevertheless, there have been swings back towards a qualitative approach; the interactionist school emerged in the areas of the sociology of deviance in the 1960s (Matza 1969, Becker 1963) and in the sociology of education and of mental illness (Young 1971, Rose 1962). This brief mention of the swing of the methodological pendulum is made in order to emphasise the fact that there is nothing particularly new about the adoption of a qualitative method and that current trends, along with the demands of the research, often dictate the methodological approach taken. Qualitative and quantitative methods both have their place in research; the qualitative method is set out here as one approach to this study. The following discussion involves a juxtaposition of the qualitative and the quantitative methods in social research in order to sharpen up some of the attributes of the approaches; it is not an attempt to discredit quantitative methods. There is little future in posing one style of research versus another and engaging in internecine debate as to the superiority of one method over the other.

Filstead (1970:4-6) refers to the 'understanding' approach as qualitative methodology and describes it as:

'Those research strategies, such as participant observation, in-depth interviewing, total participation in the activity being investigated, fieldwork etc., which allow the researcher to "get closer to the data" thereby developing the analytical conceptual and categorical components of explanation from the data itself rather than from preconceived, rigidly structured and highly quantified techniques that pigeonhole the empirical social world into operational definitions that the researcher has constructed'.

In so doing, Filstead could be accused of doing too much violence to the quantitative approach in his concern to further the case for qualitative work.

There is no reason why the two methods should not be used in harmony; it is not simply a question of one versus another. Lofland (1971:5-6) argues that there are humanistic and scientific goals involved in sociological work. The humanistic elements of the research are provided by close contacts with the informants and rich descriptions of the situation in question. The scientific goal, Lofland argues is:

'That of explicit and articulate abstraction and generalisation, or in other words, analysis'.

Lofland points out that statistical portrayals must be interpreted and given meaning in a qualitative humanistic sense:

'The bedrock of human understanding is face to face contact. Statistical sociology serves to amplify and to check on the representativeness, frequency and correlation of the knowing that is founded on that bedrock'.

The point that is being stressed is that the qualitative method has something to offer in the collection of viable data and the formulation of theory. The position adopted here is neatly summed up by

Filstead (1970:8) if we allow for his 'evangelism'; he maintains that:

'The assets of qualitative methodology in sociology need to be stressed and the shortcomings of quantitative methodology need to be exposed in their boldest relief, because the majority of sociologists are oblivious to the assets of the former, and euphoric about the techniques of the latter'.

The qualitative versus quantitative debate is potentially endless. It is, however, useful to consider the method of social research in close relation to both the substantive area in question and the theoretical background involved. Bulmer (1977:1-33) in his writings on research methods takes as his starting point:

'The interplay of problems, theories and methods in sociological research'.

Bulmer's main thesis is that methods should always be viewed in the context of the problems and theories which they are used to illuminate. This is a particularly useful point of view when faced with the qualitative versus quantitative divide. Sociologists need not pursue methodological hegemony but derive their approach from a consideration of both the problem in hand and the theory pertinent to it. In Bulmer's words:

'Like the chicken and the egg data and the interpretation of data are inextricably bound up - to conceive one without the other is to deprive sociology of its theoretical core'.

Development of Sociological theories

The qualitative approach used in this study was, to some extent, modelled on the work of Glaser and Strauss (1967) and their generation of 'grounded theory'. That is to say a theory generated from and grounded in data. Before considering the work of Glaser and Strauss, a discussion of some aspects of theory development in sociology is

offered in order to provide a context in which to set 'grounded theory'. A distinction is made between the 'positivists' and the 'verstehen' sociologists. These two schools are discussed in relation to the analytic methods employed and the mode of theory developments in each. The question of the relationship between theory and the research problem is addressed, culminating in a discussion of the use of theory.

It seems that when theory is mentioned in the social sciences a multitude of meanings can be attributed to the term. Sjoberg and Nett (1968:29-30) state that "Whenever we seek an answer to the question 'what is meant by theory in social science?' we encounter definitions that are contradictory or, at best ambiguous". They distinguish three approaches of social scientists towards theory. Firstly, those who equate any kind of conceptualisation with theory. Secondly, the social scientists who identify social theory with the writings of classical sociologists such as Weber, Durkheim, Marx etc. Thirdly, those who reserve the term theory for a formal or logico-deductive system. Sjoberg and Nett set out three main dimensions of a theory in science:

'In a broad sense a scientific theory serves to link apparently discrete observations. More specifically, it refers to a set of logically interrelated "propositions" or "statements" that are empirically meaningful, as well as to the assumptions the researcher makes about the method and his data. Thus there are three dimensions to theory in science: (i) the broad logical structure, or the form; (ii) the generalisations or propositions concerning the patterning of the empirical world (the specific content) and (iii) the assumptions regarding the scientific method and the nature of the data'.

Thus whilst Sjoberg and Mett argue that social theory can take many forms, their main thesis is that there is a need to recognise the interrelationship between theory and method.

Merton, in his *Social Theory and Social Structure* (1957) states that

'the word theory threatens to become meaningless'.

Throughout the work he uses the term sociological theory to mean

'logically interconnected sets of propositions from which empirical uniformities can be derived'.

Merton's definition of sociological theory focuses attention on theories of the 'middle range' which he describes as "theories that lie between the minor, but necessary working hypotheses that evolve in abundance during day to day research, and the all inclusive systematic efforts to develop a unified theory that will explain all the observed uniformities of social behaviour, social organisation and social change". Selltiz et al (1965:430) made the point that the use of the term theory in the scientific sense must be distinguished from its use in common parlance; in the latter sense it tends to be speculative, whereas in the former it is

'the intention of theory in modern science to summarise existing knowledge, to provide an explanation for observed events and relationships, and to predict the occurrence of as yet unobserved events and relationships on the basis of the explanatory principles embodied in the theory'.

Selltiz et al draw attention to the fact that a theory is always to some extent tentative and potentially transient, open to revision; unlike in earlier times when theories were thought to be the final explanation. Willer (1967:3) states that "a theory is an integrated set of relationships with a certain level of validity". Further, he maintains that

"before validation it is improper to refer to this set of statements as 'theory' regardless of their purity of form". He would rather the term "a set of hypotheses" was used and the "theory" label be reserved for validated hypotheses.

There is no real consensus among sociologists about the nature of theory or explanation. Social scientists make observations and seek in some way to make sense of these observations. It is this making sense of observation that is at the root of the 'what is social theory' question. Should the social scientist, in his efforts to make sense of what he sees, seek to explain observed behaviour, categorise it or, make predictive statements on the basis of his observations? The lack of consensus on this issue has some of its origins in the development of sociology as a discipline and the emergence of the different schools of thought and method.

'Positivism' and 'Verstehen' considered

Here the work of Sjoberg and Nett (1968) is drawn upon to aid the discussion of the nature of sociology and, in turn, the nature of theories and explanations. They distinguish two main schools of thought or intellectual traditions in sociology: the 'positivists' and the 'neo-idealist tradition'. Positivists assume that scientists can attain 'objective knowledge in the study of the social and natural worlds'. The positivist tradition also holds that natural and social sciences share a basic methodology, that they are similar because they employ the same logic of enquiry and similar research procedures.

The term 'positivism' was coined by Auguste Comte in the early nineteenth century. Giddens (1974:2) argues that "the term has become one of opprobrium and has been used so broadly and vaguely as a weapon

of critical attack, both in philosophy and sociology, that it has lost any claim to an accepted and standard meaning".

Kolakowski (1972:9-19) distinguishes four elements of the positivist mode of thinking and propounds them in the form of rules. Firstly, the rule of phenomenalism, which states that there is no real difference between 'essence' and 'phenomenon'. All 'knowledge' must be based on experience, that is related to a reality which can be apprehended. Secondly, and closely related to the first, is the rule of nominalism, which says "we may not assume that any insight formulated in general terms can have any real referents other than individual concrete objects". Science aims at ordering the world which we know as a collection of individual observable facts; in so doing it uses abstractions. These abstractions, Kolakowski reminds us, are "no more or less than means, human creations that serve to organise experience but that are not entitled to lay claim to any separate existence". These abstractions give us no extra, independent knowledge of the world beyond that which is founded upon experience.

The third rule is that which refuses to call value judgements and normative statements knowledge. Experience contains no such qualities as good and evil; experience cannot act in any sense as a moral dictator for action. Evaluations of a technical nature are possible, and statements of true and false can be made with regard to the success or otherwise of an operation in achieving a desired end, but nothing can be said about the worth of that end. The fourth element identified by Kolakowski is a belief in the essential unity of the scientific method. This unity implies that there are no qualitative differences between methods for acquiring valid knowledge in all spheres of experience. Some positivists believe that all knowledge

will be reduced to a single science, usually thought to be physics. This choice is made on the grounds that among the empirical disciplines, it has developed the most exact methods of description and encompasses the most universal of the phenomena found in nature.

Around these four rules, Kolakowski states, positivist philosophy has built up an extensive network of theory covering all domains of human knowledge. Defined in broad terms Kolakowski says "positivism is a collection of prohibitions concerning human knowledge, intended to confine the name 'knowledge' or 'science' to the results of those operations that are observable in the evolution of the modern sciences of nature".

Giddens (1974:3-4) argues that 'positivism' has meant somewhat different things to philosophers and sociologists and has consequently set out three connected suppositions which the positivistic attitude in sociology contains. Firstly, that the methodological procedures of natural science may be directly adapted to sociology. Social conduct can be treated as 'object' just as objects in the natural world are treated; human subjectivity is not seen as a barrier. Secondly, Giddens argues that the goal of sociological analysis can and must be to formulate 'laws' or 'law-like' generalisations, of the same kind as those formulated in the natural sciences. Thirdly, that sociology, like natural science, is 'neutral' in respect of values. That is to say sociology has a technical character and its research findings do not carry any logically given implications for either practical policy or the pursuit of values.

It is this narrower view of positivism within sociology, rather than the broader philosophical sense, to which Sjoberg and Nett refer in their analysis of the intellectual traditions in sociology.

The 'neo-idealist' school, notably Dilthey (cf. Hodges 1944) and Weber, held that the natural and social sciences are separate entities and must therefore require different research strategies. They claimed that social scientists must take into account both the historical dimension of human action and the subjective aspects of human experience (Sjoberg and Nett). It was out of this tradition that Weber developed his notion of 'verstehen' or understanding. 'Verstehen' is the descriptive term used by Weber to convey his insistence on the subjective point of view in the social sciences. Parsons, in his introduction to the translation of Weber's (tr. Parsons 1947:8) "The Theory of Social and Economic Organization" describes the position as:

'A system of sociological categories couched in terms of the subjective point of view, that is of the meaning of persons, things, ideas, normative patterns and motives from the point of view of the persons whose action is being studied'.

For Weber (1947:80-89) sociology is "a science which attempts the interpretive understanding of social action in order thereby to arrive at a causal explanation of its course and effects". Weber distinguished two types of understanding, one which is arrived at by 'direct observation' and a second, 'explanatory understanding', which is arrived at in terms of 'motive'. It is the second type of understanding which is crucial in the interpretive approach to data. Weber defines a motive as "a complex of subjective meaning which seems

to the actor himself or to an observer an adequate ground for the conduct in question". Thus, the central idea of 'verstehen' is that the understanding of meaning is essential to the explanation of human action. If social scientists are to make sense of the social action of individuals or groups, then they must 'understand' the action from the subjective point of view of the actor or actors; social scientists must in Mead's (1934:254) terminology "take on the role of the other".

This 'understanding' approach to sociology has been taken up by others, who use what can generally be described as interpretive methods, and depend heavily upon getting close to the data, which is frequently collected by participant techniques (Becker 1961, Cicourel 1968, 1974, Glaser and Strauss 1965). The positivists, on the other hand, are convinced largely by empirical data. Sjoberg and Nett (1968:69) sum up the two positions, 'verstehen' and 'positivism' thus:

'The former conceive of social reality as fluid and emerging, with no sharp distinction between the scientist and the data of observation; they use the actor's frame of reference in analysing and collecting their data. Ultimately they utilise understanding in testing the validity of their theory. The positivists, on the other hand, tend to view reality in mechanistic terms and assume the existence of a sharp dividing line between the scientists and the data of observation. They tend to ignore the actor's perspective. In the end the positivists would judge a theory's validity in terms of its predictability'.

This distinction between positivists and verstehen sociologists, which Sjoberg and Nett make affords, necessarily, a simplistic view of sociological endeavour. Sjoberg and Nett, themselves, recognise that to distinguish between sociologists' approach to the development of theory according to their major assumptions has its limitations.

However, they maintained that it was a helpful distinction to make in considering 'Methodologies for Social Research'. Their example is followed in the present chapter, where the distinction will serve to focus the discussion of sociological theory, and the scope for developing, after Glaser and Strauss, a "grounded substantive theory". There are obvious limitations to dividing sociologists up in to two distinct groups; it necessarily misses the subtle combinations of approach achieved by some sociologists. Indeed, Weber himself, the protagonist of verstehen, attempted "to incorporate both 'causal explanations' and 'interpretive understanding' into sociology". As Goudsblom (1977:183-84) points out:

'In the first paragraph of Economy and Society (1922, p.9) Weber bridged, in one sentence, the seemingly insurmountable cleavage between the two methodological traditions'.

The sentence to which Goudsblom refers is Weber's definition of sociology as "a science which seeks to understand social action interpretively and thereby to explain it causally in its course and its effects". Goudsblom argues that, despite Weber's concern for the 'substantive meanings', "his design for interpretive sociology is actually objectifying and formalistic". Goudsblom likens Weber's approach to meanings, by way of formal categories 'ideal types' to Durkheim's types of suicide, which Goudsblom says "are constructs invented by a sociologist, and not categories in which certain groups of people order their own experiences".

Uses of Theory

The place of theory in sociology is then, a much vexed question. Essentially there are two contexts in which theory can be problematic. Firstly, in the relationship between the theory and the method used to arrive at it; secondly, the purpose which the theory serves. These two issues are addressed below.

The relationship between the theory and the research method varies depending upon whether the theory is being used to direct the research or the research is being undertaken in order to develop a theory. In the first case an existing theory can be used to explain or interpret the data, or indeed the data might simply uphold an existing theory. Deductive reasoning from the general to the particular is the underlying principle here. In the second case, that of theory development, the sociologist arrives at a theory inductively, that is he analyses the data and puts his own sociological interpretation upon them and thus formulates a theory. These two approaches, deduction and induction, are by no means mutually exclusive. Even empirists such as those described by Allen (1975:3) who "believe that facts are impartial and as such can tell their own stories, undisturbed by theories" make certain assumptions about the nature of the phenomena they analyse; and as such can be said to have an implicit hidden theory.

Thomas and Znaniecki (1918-20) claimed in "The Polish Peasant" to have used inductive reasoning to arrive at their 'laws' about social organisation and social change among Polish immigrants to America. This work was hailed as a milestone in the history of American sociology, introducing such concepts as 'value', 'attitude' and 'definition of the

situation' to the sociological literature. However, in response to Blumer's criticism (1939) that the basis of the theories put forward lay in the 'intimate familiarity' of the authors with the life of Polish Americans, Thomas and Znaniecki acknowledged that the link between the documentary and theoretical parts of the "Polish Peasant" was tenuous. This, according to Goudsblom (1977:45) demonstrated that "sociological facts could only be established and interpreted within a previously conceived theoretical scheme". Znaniecki (in Blumer 1939:91) in his comment on Blumer's critique said:

'No inductive science ever draws valid theory directly and exclusively from facts as they are given in naive observation, undirected and unrelated to previous theory. A fact is theoretically significant - is, indeed, a fact at all in the scientific sense - only if it serves either to raise a problem or to solve a problem. The former happens when a ready hypothesis is applied to it; the latter when a new hypothesis is based upon it'.

Whatever the ultimate relationship between theory and method, the two should be considered along with the research problem. As Bulmer (1977:4-5) has argued well, it is the relationship between the problem, the theory and the general methodology that lies at the heart of the 'which research method' debate. The 'general methodology' he defines as:

'The systematic and logical study of the general principles guiding sociological investigation, concerned in the broadest sense with questions of how the sociologist establishes social knowledge, and how he can convince others that his knowledge is correct'.

This question of simultaneous consideration of the method, theory and the research problem is linked with the second issue, namely, what purpose is the theory to serve. Once the method has been chosen and deemed to be a useful way of approaching the research problem, the major remaining question is - is the theory thus developed useful, what

is its function? It has been argued above that there are various expectations of a theory, in terms of whether it should be explanatory or predictive.

At its simplest level, a theory can be seen to provide a way of relating concepts to each other in order to explain certain aspects of reality. Sjoberg and Nett describe the two kinds of explanation in the social sciences: 'verstehen' or understanding, and prediction. The 'verstehen' approach to data contends that an understanding of the data can lead to a sufficiently clear explanation which can be formulated as a theory and thus account for the data. The positivists, on the other hand, see prediction of events in a given area, on the basis of their data, as the key to adequate explanation of data and consequent theory building. In Sjoberg and Nett's (1968:290) words:

'(verstehen sociologists) reject the notion of predicting human action in strictly mechanistic terms. Because of man's active role in reshaping his environment, many of these sociologists reason that we must rely upon theories that stress understanding rather than those that stress prediction per se'.

If we remember the original distinction between the 'positivists' and the 'verstehen' sociologists, it can be argued that these two schools are as much divided in their view of the purpose of theory as they are in their methodological approach to social research. This is not necessarily to say that the choice of method alone affects the type of theory developed; although to some extent it conceivably must; it is more probable that the kind of theory developed will be dictated by and in line with the researcher's sociological stance.

Whether or not the theory explains or predicts we are still left with the problem of knowing whether it accurately explains or predicts the realities of the data. In social science there is no real outside world of 'facts' with which the data can be said to be checked and said to be 'right'. Rex (1961:9-10) contrasts Durkheim's conception of the 'average type' and Weber's 'ideal type'. He says that Durkheim's purpose is primarily descriptive, in that he uses 'average type' because he cannot discuss every empirical instance individually. The average type is seen as "the best method of achieving some measure of generalisation, whilst at the same time remaining faithful to the facts". The 'ideal type', on the other hand, is distinguished sharply, by Weber, from the idea of an average type. Weber used his 'ideal type' as a means of explanation not merely description. As Rex put it:

'(Weber) also insists that it is the construction of the scientist rather than something which emerges in a simple way from the facts'.

Rex continues that:

'Durkheim's average type is probably more of a theoretical construction than his empiricism would allow him to admit, and Weber's "ideal type" is probably less pure than he suggests. Both are concepts which are intended for use at the point at which theory and description confront one another'.

Generation of 'grounded theory'

The point which Rex (1961) makes about description and theory confronting one another is pertinent to the discussion of 'grounded theory'. The central idea in 'grounded theory' generation is that theory is generated from data by the procedures of induction. A full discussion of the work of Glaser and Strauss is offered here in order to set out the idea of generating theory from data. It is offered

with the following caveats. Firstly, the arrival at a theory by inductive methods is by no means new to sociology. Analytic induction was described by Znaniecki in 1934 and has been elaborated by Robinson (1951) and Cressey (1950); these works are discussed in Chapter 4. The methods of Glaser and Strauss should be examined in the light of this fact. The second caveat is that the discussion of 'grounded theory' generation offered by Glaser and Strauss is rather nebulous in parts and as a result it is somewhat difficult to be clear about their intentions. However, they do not offer the book as a 'how to do it' research manual but as a "book directed toward improving social scientists' capacities for generating theory that will be relevant to their research". They further claim to keep the discussion "open minded, to stimulate rather than freeze thinking about the topic". The whole approach to the work means that, in using it, the researcher must be constantly aware of how far he is remaining faithful to the spirit of grounded theory generation, given that there is wide scope for variance in the actual methods employed.

Glaser and Strauss describe the generation of 'grounded theory' in a methodological work, which was written in order to develop the research strategy used in a study of dying patients in American hospitals (Glaser and Strauss 1965). This account of the development of grounded theory was considered before embarking on the present study because of the desire on the part of the researcher to adopt a 'verstehen' approach to the work and to proceed inductively.

Glaser and Strauss talk of the 'great men', Durkheim, Weber, Marx who:

'Generated a sufficient number of outstanding theories on enough areas of social life to last for a long while'.

They argue that:

'A few men (like Parsons and Merton) have seen through this charismatic view of the great men sufficiently to generate "grand" theories of their own. But even these few have lacked methods for generating theory from data, or at any rate, have not written about their methods. They have played "theoretical capitalists" to the mass of "proletariat" testers, by training young sociologists to test their teachers' work but not to imitate it'. (Glaser and Strauss 1967:10)

Historically, as Glaser and Strauss point out, the change of emphasis from generation of theory to its verification was linked with the clash between quantitative and qualitative data. They argue that each form of data is useful for both the generation and verification of theory. In a paper describing the "Discovery of Substantive Theory" (1965), Glaser and Strauss state that:

'Sociologists over-emphasise rigorous testing of hypotheses and de-emphasise the discovery of what concepts and hypotheses are relevant for the substantive area being researched'.

They further contend that:

'Qualitative research quite apart from its usefulness as a prelude to quantitative research should be scrutinised for its usefulness in the discovery of substantive theory'.

By substantive theory they mean:

'The formulation of concepts and their inter-relation into a set of hypotheses for a given substantive area - such as patient care, gang behaviour or education - based on research in the area'.

Glaser and Strauss put forward a method for generating theory from data using 'theoretical sampling'.

'Theoretical sampling' is the process of data collection for generating theory whereby the analyst jointly collects, codes and analyses his data and decides what data to collect next and where to find them in order to develop his theory as it emerges'.

According to Glaser and Strauss, theory is in sociology "a strategy for handling data in research, providing modes of conceptualisation for describing and explaining"; they make three main points about theory. Firstly, that theory based on data can usually not be refuted by more data or replaced by another theory - it can be reformulated or modified but it will last. (1) Secondly, the adequacy of theory for sociology cannot be divorced from the process by which it is generated. Glaser and Strauss argue that a theory will be a better one to the degree that it has been inductively developed, from social research. Thirdly, the theory should 'fit' the situation being researched and 'work' when put to use.

'By "fit" we mean that the categories must be readily (not forcibly) applicable to and indicated by the data under study; by "work" we mean that they must be meaningfully relevant to and be able to explain the behaviour under study'.

One of the major distinctions Glaser and Strauss draw is that between 'theoretical sampling' and 'statistical sampling' (random).

Theoretical sampling is based on what Glaser and Strauss call 'saturation of categories'. Categories are the conceptual elements of the theory; they provide a means of classifying the data in an abstract way which makes them possible to consider. Categories are said to be saturated when no additional data are being found which can develop the

(1) This contention the researcher finds a little too sanguine; as it puts into question the worth of such a theory.

category any further; when no new aspects are emerging. In short, the sample is not one which is predetermined numerically, and one which must be worked through, rather data are collected so long, and only so long as they are adding to the development of a particular category. Once a situation is reached where nothing new is emerging, the category is deemed to be saturated. In the words of Glaser and Strauss (1967:62) the difference between 'theoretical sampling' and 'statistical sampling' is this:

'Theoretical sampling is done in order to discover theoretical categories and their properties, and to suggest the interrelationships into a theory. Statistical sampling is done to obtain accurate evidence on distributions of people among categories, to be used in descriptions or verifications'.

Theoretical sampling is carried out in the overall strategy of constant comparative method which Glaser and Strauss describe as the way to proceed in order to generate 'grounded theory'. This method is described below.

Firstly, by comparing incident for incident in the data, the analyst establishes the underlying uniformity of the phenomenon, and its varying conditions; these become the emergent concept. The analyst then compares these concepts with further incidents; this allows for elaboration of the theory and saturation of categories. Finally, he compares concept with concept in order to establish the best fit of concepts to the data which indicated them. This process becomes clearer with an example from their data.

'When the analyst observes several doctors and nurses hovering over a VIP on an intensive care unit, and he observes the ignoring of a lower class black on emergency ward with a gaping knife wound, he may generate the concepts "social value" of a patient and medical attention and the hypotheses that the higher the social

value the more and quicker the medical attention under the condition of immediate need of care'.

When the analyst compares further incidents with his concepts:

'When the medical team discover that the dentist in emergency is actually a derelict alcoholic who has not practised for years their attention and effort may shift to others. Social value is both apparent and recalculated as further aspects are learned about the patient'.

Lastly, when concept is compared with concept:

'The analyst may have generated the concept of social value of patients when looking at a full spectrum of patients who are recovering and dying, and the concept of social loss when just looking at dying. "Social value" is on a higher level of generality than "social loss", since it implies the latter as its scope encompasses all patients, including dying patients. For dying patients, either concept may work well but social loss fits better into the imagery of the theory' (Glaser 1978:49-50).

As it has been suggested above, some sociologists would argue that this method of arriving at theory from data is not all that new. Bechhofer (1974:77-78) whilst applauding Glaser and Strauss' call for the generation of theory rather than theory testing, stated, in his discussion of their notion of theoretical sampling, that:

'The search for contrasting empirical situations is suggested by good experimental practices, and the search for conceptually related, but empirically different situations is very much good scientific practice'.

Bechhofer concludes his critique by reiterating that he does not wish to belittle the 'theoretical sampling' procedure, but

'rather to suggest that it simply makes explicit what good sociologists have done for a long time, and that it is quite reconcilable with scientific method and theory development viewed as what scientists actually do, rather than as a mechanical and rather automatic procedure'.

The 'grounded theory' approach has the appeal of flexibility in that the emerging conceptual categories direct the future data collection, and unforeseen lines of inquiry can be pursued in a way which is not possible with more rigid research designs.

Why generate 'grounded theory'?

Two main issues arise from the discussion of sociological theories which are pertinent to the generation of 'grounded theory'. First to be considered is the method of handling the data in the grounded theory approach; whereby categories are used to describe, in conceptual terms, the data and thus build theory. The 'categories' of Glaser and Strauss have similar conceptual uses to the 'ideal types' of Weber. As it has been argued above, these labels for data are useful when theory and description confront one another. For descriptive purposes the notion of an 'average type' (Durkheim) is appropriate whereas, for abstract thought, categories and the 'ideal types' (Weber) are conceptually useful. Indeed, they are the very means by which the findings are moved from the descriptive to the explanatory. Secondly, in connection with the sampling issue comes the question of generalisability of findings. If the data are subjected to inductive procedures and a theory developed, what, then, does this theory have to offer in terms of a sociological explanation beyond the data in which it was grounded?

It is maintained here that sociologists must start with the assumption that there are regularities in the social world to which they can, through patient study, have access. Thus, although the inductively developed theory does not have the extra 'edge' that it might have if it could claim a basis in a large, randomly selected, sample, it does still have the explanatory powers required of a theory,

plus the qualitative depths which other methods do not allow. The ultimate answer to this question lies with the theory which is eventually developed. If indeed the theory does explain some aspects of, in the case of the present study, the student nurses' world, then the method used to arrive at the theory grows in stature.

The notion of 'grounded theory' development in relation to the present study is taken up in the last chapter. For the present, suffice it to say that it was the spirit rather than the letter of 'grounded theory' which guided this study. This chapter has provided a general introduction to qualitative methodology, the next addresses itself to the method employed in this study.

CHAPTER 3

Methodological issues and fieldwork

1. INTRODUCTION

This chapter is concerned with the research technique adopted for the study, namely, the informal interview. The chapter opens with a brief description of fieldwork and the interactionist perspective and continues to consider, in turn, the fieldwork literature, the early days of the interviewing, a demographic picture of the students interviewed and, lastly, the process of doing the fieldwork.

It will make the task clearer if we anticipate a little and state the nature of the data, and their mode of collection, before considering the details of the method. The data comprise forty tape recorded interviews which the researcher undertook with student nurses. These interviews were transcribed and the original tapes preserved; thus the data are in both recorded and written form.

The literature reviewed is concerned with the interview as a technique of data collection and with 'fieldwork' methods; in particular with participant observation. The generic term 'fieldwork' is a useful description of the method adopted in this study. Schatzman and Strauss (1973), in a discussion of 'field research', encompass various qualitative research methods and consider their usefulness as 'strategies for a natural sociology'; the emphasis being on the 'natural'. There are several strategies available to the researcher who wishes to make a study of a phenomenon from the perspective of the subjects of the research. These include participant observation, interview and the use of life histories and documents as research data. The method of data collection most commonly associated with qualitative research is

participant observation. Indeed it tends to be the most frequently described field research strategy and, as such, almost becomes synonymous with the qualitative method.

A qualitative fieldwork approach was taken in this study in order to yield data which allow some explanation of nursing from the point of view of the student nurse. The way in which data are obtained constitutes an important part of the construction of the data, the researcher must begin by analysing the perspectives of the participants in order to elicit the social meanings of their actions. In this endeavour it is the researcher's job to produce an account of how the participants see the situation or phenomenon in question; the analysis then goes beyond this point when analytic concepts, which transcend the meanings of the actors, are developed. To a large extent, the production of the participants' perspective depends upon the researcher's knowledge of the social setting. Participation in the setting for long periods allows this knowledge to develop. In the present study the researcher was to some degree familiar with the setting of which the students were providing their accounts. The researcher had practised as a nurse and, as such, was familiar with nursing jargon and the ways of hospitals in general. In this respect, then, the researcher did not enter the research situation from a position of entire naïvete. However, the researcher's experience of nurse training was not that of a conventional three year programme, neither was it undertaken in the hospitals in this study.

Participant observation stresses the part played by the researcher in the generation of the data; the observer's aim is to provide an account of the phenomenon and an explanation of it through an

understanding of the perspective of the 'actors'. It is this production of data through interaction with the subjects of the research which is crucial in fieldwork. By the very nature of the method the researcher and the data are inextricably bound up. It is contended here that the close involvement of the researcher in the production of the data is as true of the informal interview method as it is of participant observation. The field data produced are handled in much the same way as the field notes of participant observation might be handled; hence the distinction between interview and participant observation, insofar as it is made in the review of the literature, is not such a clear cut one when data collection and analysis are considered empirically rather than conceptually.

The interview data represent the students' perspectives on nursing and are handled as fieldnotes, or interview data from an interview undertaken during participant observation, might be handled. It is not the intention here to claim that the methods are entirely interchangeable, clearly the data yield will be different, but not, it is contended, greatly so. The important point is that the data produced by fieldwork provide an account of a situation from the actor's perspective. In the informal interviews the students described their experiences, and in a sense, could be said to be replaying events from their nursing world for the benefit of the researcher. Thus the informal interview seems to sit more comfortably among other 'fieldwork' strategies than alongside the more structured versions of the interview, as employed in survey work.

As a research strategy participant observation has become closely linked with the sociological perspective of symbolic interactionism. Before proceeding to describe the method of data collection a brief description of the 'interactionist' perspective is offered.

Symbolic interactionism

Interactionism is not a unified perspective in sociology. Rock (1979:32), in a discussion of the 'roots of symbolic interactionism', states:

'Instead of representing the fruits of an American version of the immaculate conception, (interactionism) shares an intellectual parentage with Marxism, Durkheimian functionalism, phenomenology, positivism and the sociology of Max Weber'.

Blumer (1962) provides us with a clear description of the perspective when he says:

'The term "symbolic interaction" refers, of course, to the peculiar and distinctive character of interaction as it takes place between human beings. The peculiarity consists of the fact that human beings interpret or "define" each other's actions instead of merely reacting to each other's actions. Thus, human interaction is mediated by the use of symbols, by interpretation, or by ascertaining the meaning of one another's actions'. (in Rose 1962:179)

Contemporary interactionism, Rock (1979:4) tells us, "must be understood as a culmination of prolonged thought. Its hostility to detailed explanation reflects an aversion to certain forms of rationality". The perspective has been one handed down very much by oral tradition. A group of social scientists at the University of Chicago was largely responsible for the development and growth of the interactionist perspective; the teachings of George Herbert Mead at Chicago in the mid-1920s furnish its central ideas. Much of the

systematic publication of Mead's (1934) work was, however, achieved posthumously on the basis of his students' lecture notes (cf. Blumer). Other sociologists at Chicago, notably Everett Hughes, added empirical weight to the perspective through their research.

The interactionist perspective has survived and become what now appears to be a minority tradition, which is at odds with mainstream sociology. Interestingly, as Rock points out, in its early days symbolic interactionism and American sociology were virtually one; but, as the more explicitly systematised functionalist perspective took hold, symbolic interactionism was displaced. It must be said, however, that many sociologists who engage in 'fieldwork' of one kind or another would not willingly adopt the label of 'symbolic interactionist'; and, hence, the label is not entirely satisfactory. Although, if such sociologists had to accept some perspective-oriented title, that of interactionist would be the most apposite (Cuff and Payne 1979).

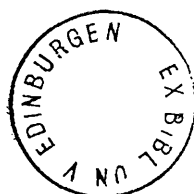
The underlying theme of Mead's work is the distinction between 'animal reaction' and 'human conduct'; conduct is based upon the possession of a mind. Man, he argues, can be both the object of an experience and the subject insofar as he is aware of experiences. Mead argues that man has a 'self', that is that he can react socially towards himself as well as towards others. Society according to Mead operates by means of 'significant symbols' which have a shared common meaning; these symbols are words which man uses to communicate. Mead's position is neatly summed up by Meltzer:

'The human individual is born into a society characterised by symbolic interaction. The use of significant symbols by those around him enables him to pass from the conversation of gestures - which involves direct unmeaningful response to the overt acts of others - to the occasional "taking of roles" of others. This "role taking" enables him to share the perspectives of others. Concurrent with role taking the self develops, i.e. the capacity to act towards oneself. Action toward oneself comes from viewing oneself from the standpoint or perspective, of the "generalised other" (the composite representative of others, of society, within the individual). Which implies defining one's behaviour in terms of the expectations of others' (Manis and Meltzer 1972:17-18).

Insofar as man is both subject and object of experience, deterministic explanations of human action do not satisfy the interactionist. Man is able to interact with and respond to the social entities with which he comes into contact; thus, an individual's action is the result of his negotiations with the social realities he encounters. Blumer (1962) argues that most sociologists ignore the perspectives of the subjects of their research; they tend to view human society in terms of structure and organisation and to treat social action as an expression of structure and organisation. Thus he says:

'Reliance is placed on such structural categories as social system, culture, norms, values, social stratification, status positions, social roles and institutional organisation' (in Rose 1962:188).

These, he says, are concepts which are used to analyse society and to account for social action within it. Blumer goes on to say that, from the standpoint of symbolic interaction, social organisation should be seen as a framework within which acting units develop their actions:



'Structural features, such as "culture", "social systems", "social stratification" or "social roles", set conditions for their action but do not determine their action. People - that is, acting units - do not act toward culture, social structure and the like; they act toward situations'. (in Rose 1962:189-190)

A final question is posed by Blumer, namely, whether society or social action can be successfully analysed by schemes which refuse to recognise human beings for what they are, that: "persons constructing individual and collective action through an interpretation of the situations which confront them". Rock (1979), in a discussion of social forms, which draws on the work of Simmel, goes some way towards answering this question.

Rock (1979:36-37) points out that man is not reacting with given realities which can be said to exist in some real, 'out there', sense.⁽¹⁾ Society and social action do not have an independent existence; in Rock's words:

'The attempt to adjudicate what is the irreducibly real unit of social existence is an absurd exercise because all phenomena are the synthetic creations of those who deal with them. All that men confront is an environment of constructions which they have organised out of experience'.

Men, Rock argues, produce society by their interactions with each other, they impose structure upon it in an attempt to understand it.

Thus:

'All phenomena are artificial and, in the sense that they could be otherwise, they are also arbitrary. They are neither invented nor discovered, but produced. Society and its components are ongoing accomplishments, they are in a state of continual production as their members actively impose order on the world. They have no reality outside that accomplishment'.

(1) 'Man' is used merely as a stylistically convenient term.

Rock takes up Simmel's notions of 'social forms' and 'sociation'; the latter referring to the orderly interaction which ensues when individuals encounter one another and engage in mutually responsive conduct. The 'social forms' are the vehicles by which individuals accomplish the contents of their interactions. The forms provide the means by which others might recognise and make sense of the content of unique human interactions. Without these forms Rock (1979:40) argues, the contents cannot be known; he says:

'It was through the production, recognition and resolution of forms that sociation became structured, intelligible and concerted action. In forms, individuals transcend themselves. They cease to be isolated atoms and become parts of systems of sociation whose properties cannot be inferred from their separate characters alone. Whenever people speak, meet, make love, fight or play they realise the contents of their behaviour in social forms. Without those forms the contents would be destined to remain permanently inarticulate and unknown. With those forms they are transmuted and harnessed'.

Thus, social forms are, as Rock puts it, 'the currency of social intercourse'. They make the contents intelligible but are also regulated by properties which have their own logic. In the sense that forms take on an existence, which is independent of content, they can be employed to order individual's interpretations of situations. Thus, forms become for Simmel, Rock tells us, "synthetic a priori modes of knowledge which lent unity and organisation to the potentially anarchic universe of experience. It was through forms that the sociologist and actor alike conferred order on what they did and saw".

Social forms, then, allow for some structuring of what would otherwise be unintelligible content; whilst not denying that the order is imposed by man in his attempt to understand his world. Thus,

social forms do not represent the type of schemes Blumer refers to which do not recognise the interpretive work which human beings do on the situations which confront them. The interactionist's viewpoint should be perhaps tempered with caution for, as Rock (1979:43) points out:

'In all their manifestations, however, the forms can become so liberated that they are experienced as externally coercive objects which limit choice, restrict perspectives and infuse motivation ... There is thus a constant war between man and the language of forms which he must employ. His life is forever being externalised into a fixed organisation which impairs his capacity to develop. Moreover, as these forms take on an autonomy, so they achieve an objective logic of their own'.

Interactionists insist that the organisation of social life arises from within the society itself and out of the processes of interaction between members of that society. Whilst not discounting the influence of external factors, of, for example, physical environment, interactionists argue that their impact upon mans' social action is dependent upon mans' adaptation to these external factors. The structuralist approach which states, broadly, that the actions taken, values held and relationships formed, by individuals in a society are the products of, or at least greatly influenced by, the structure and organisation of that society. Interactionists reject this structuralism because it reduces the individual's actions to mere reactions to external forces. Symbolic interactionists

'Do not see society in some kind of well defined tightly integrated system of parts. Rather, "society" is seen to be a rather loose arrangement of quite heterogeneous groupings - occupational, organisational, ethnic, class, status, political, religious and so on'. (Cuff and Payne 1979:18)

In this sense structure is seen to be there but much more open to 'negotiation' and less imposed. Strauss et al (1963) used the concept of 'negotiated order' to describe this interactionist view of society and its organisation.

The interactionist perspective is far from succinct and unified; it does have at its heart a concern for the meaning of social action from the perspective of the participants. Thus, both the perspective and the associated methods are firmly based in the Weberian tradition of 'verstehen'. Skidmore (1979:233) puts the case for symbolic interactionism thus:

'Is there no sense, then, in which symbolic interactionism can be said to "explain" social life? It does not do it very successfully by rigorous deductive methods or by establishing covering laws and advancing hypotheses. Yet as a method of making one understand by telling a tale in terms of a perspective on human affairs, all the while asserting that this perspective is really "the way it is", interactionism achieves a "soft" explanatory style that is valuable to sociology in its own way'.

2. THE FIELDWORK LITERATURE

The informal interview method of data collection presented some difficulty in terms of literature to be consulted. The large literature concerned with interviewing techniques, whilst offering some useful insights, was all too often firmly rooted in the methods of the survey researcher. On the other hand, an examination of the qualitative literature reveals that much of this research involves participant observation as a fieldwork strategy. Thus for the purposes of the present study the researcher consulted both the interview literature and that concerned with participant observation.

Participant observation has been employed to study the work of nurses, Kratz (1974) looked at the work of community nurses with stroke patients. Towell (1975) employed the strategy in a study concerned with understanding psychiatric nursing and Dingwall (1977) used the method in a study of Health Visitor training. In the present study it was how the students viewed their nursing world that interested the researcher; whilst participant observation could have been undertaken, the informal interview was settled upon. It was felt that, provided sufficient rapport and informality could be established, many of the advantages of the participant observation method, in terms of data yield, could be attained without engaging in the long bouts of fieldwork required in participant observation.

Junker (1952) described four theoretically possible roles which a sociologist, carrying out fieldwork, might adopt. These roles were further investigated and described by a member of his research team, Gold. Gold (1958) presents the roles as a continuum ranging from the complete observer to the complete participant; in between these extremes lie the observer-as-participant and the participant-as-observer. The complete participant role entails the researcher concealing his identity and purpose from those whom he studies. He then takes part in all the activities of the group and interacts with the members as if he were truly one of their number. Similar behaviour is displayed by the researcher adopting the participant-as-observer role; the crucial difference being that he reveals his identity and purpose to the group. The complete observer role involves the researcher removing himself entirely from the subjects

of his research; in this role he does not interact socially with his informants. The observer-as-participant role Gold describes as that "used in studies involving one-visit interviews".

The difficulties, mentioned above, concerning placing the data collection technique used in this study among the fieldwork methods are to an extent, resolved by reference to Gold's work. The informal interviews, undertaken in this study, can be placed on a structured-unstructured continuum, lying closer to the latter end. If, however, one considers the researcher's role rather than the nature of the interviews, then the researcher can be said to have adopted, in Gold's terminology, an observer-as-participant role. Within the context of the other observer fieldwork roles, this one, according to Gold, "calls for relatively more formal observation". He also points up its weaknesses, which he argues stem from the fact that the researcher has only brief encounters with informants. The brevity of the encounters, Gold suggests, might lead to misunderstandings on the part of both interviewer and informant. The lack of a continuing relationship denies the researcher the opportunity to correct any misunderstandings and other difficulties encountered with the observer-informant relationship.

Becker et al (1961) in the study of medical students which has been discussed above, used participant observation as a means of data collection. They took on participant-as-observer roles. This meant that they followed the medical students not only through their lectures, demonstrations, clinical and laboratory work but also into their leisure time, in the residences, canteen, bars etc. The students and faculty staff were aware of the researchers' observer role even though they participated so fully.

In a paper discussing the merits of this method Becker and Geer (1957) state that:

'the most complete form of the sociological datum, after all, is the form in which the participant observer gathers it: an observation of some social event, the events which precede and follow it and definitions of its meaning by participants and spectators, before, during and after its occurrence. Such a datum gives us more information about the event under study than data gathered by any other sociological method. Participant observation can thus provide us with a yardstick against which to measure the completeness of data gathered in other ways, a model which can serve to let us know what orders of information escape us when we use other methods'.

Whilst some sympathy can be extended to Becker and Geer in their enthusiasm for a useful method, it does seem that their attitude towards other methods of data collection is somewhat narrow. Trow (1957) takes exception to the 'yardstick' position which Becker and Geer give to participant observation. He says:

'It is with this assertion that a given method of collecting data - any method - has an inherent superiority over others by virtue of its special qualities and divorced from the nature of the problem studied that I take sharp issue'.

He offers a less contentious alternative:

'That different kinds of information about man and society are gathered most fully and economically in different ways and that the problem under investigation properly dictates the method of investigation'.

Becker and Geer (1957) compare their fieldwork results with "what might be regarded as the first step in the other direction along this continuum: the detailed conversational interview (often referred to as the unstructured or undirected interview)". It is this "step in the other direction" which is discussed here.

An interview, as defined by Maccoby and Maccoby (1954:499) is "a face to face verbal interchange in which one person, the interviewer,

attempts to elicit information or expression of opinions or belief from another person or persons". Richardson et al (1965) classify interviews by their degree of structuring or standardisation. The aim of the structured interview is to achieve standardisation of the data. It is used primarily to verify hypotheses derived from existing theories (Sjoberg and Nett 1968:193). There are several advantages of the structured interview; it is relatively cheap, efficient in terms of time and the groundwork for analysis can be incorporated in the instrument. That is not to say that the validity is guaranteed; "standardised questions with fixed choice answers provide a solution to the problem of meaning by simply avoiding it" (Cicourel 1964:108). As Sjoberg and Nett (1968) also observe, the greatest disadvantage of the structured interview is the imposition of the researcher's own categories on the data.

Such imposition is also possible with data collected in an unstructured interview. Sjoberg and Nett (1968:195-196) pose this disadvantage rather sharply:

'the researcher's own methodological and theoretical commitments structure the manner in which he begins his questionnaire ... The social scientist who values the formal testing of hypothesis more than he does discovery, is apt to devise rather rigid categories for his questions, to pre-code the latter and to design dummy tables, all in the course of developing the questionnaire. Typically he then proceeds to collect the materials, summarises them according to some pre-arranged plan, fits the data into the tables and carries out the predetermined statistical analysis'.

This point which Sjoberg and Nett spell out so clearly means that there is no room for the emergence of information which has not been foreseen.

A well established example of the difficulties encountered in interview technique lies in the work of Roethlisberger and Dickson (1939:271). In their classic study "Management and the Worker", Roethlisberger and Dickson give an illuminating account of the turnabout in interview technique which took place during the study. The interviews with employees were initially undertaken in traditional personnel department style with the interviewer leading the conversation and the employee following. The authors state that:

'As the interviewers became more aware of the kind of material that they were trying to elicit from the worker, they found that for several reasons the questionnaire method, or direct type of interviewing, was unsatisfactory - the direct type of interviewing tended to elicit opinions on topics which the interviewer rather than the employee thought to be of importance'.

It is interesting to note that such was the faith placed in the 'direct interview' method that its shortcomings were only discovered in the Hawthorne studies quite fortuitously, when a group of interviewers were discussing the difficulty of interviewees' 'wandering' off the topic. In the words of Roethlisberger and Dickson "this conference marked a turning point in the interviewing method; it revealed certain obvious defects in the direct question method". They did, however, recognise that the interviewer must play some active role and give some direction to the interview when they stated that:

'On the one hand, an indirect type of interviewing was preferable if the spontaneous convictions of the worker were to be obtained, and these could only be obtained by not asking too many questions and by following rather than leading the interviewee. On the other hand, this method had its limitations for if the interviewer asked too few questions the interview tended to remain at the level of polite conversation'.

Interviews which are free of many of the constraints of the structured interview are sometimes termed 'unstructured interviews'. The label 'unstructured' is something of a misnomer because such interviews often do, in fact, have some degree of structure, albeit covert. It is the underlying structure which distinguishes a purposeful interview from a social conversation. The researcher must have defined goals for the interview. Bogdan and Taylor (1975:108) say, with reference to the interview:

'If you understand your goals, your subject and the interview situation, there is a wide latitude in what you can do. What is ultimately important is not your procedures but rather your frame of reference'.

The term 'informal interview' is used to describe those undertaken in the present study; 'informal' conveys the conversational, flexible style without denying such structure as there was.

The informal interview takes the form of a conversation. Schatzman and Strauss (1973:73) describe such interviews usefully:

'The interviewer does not use a specific ordered list of questions or topics because this amount of formality would destroy the conversational style. He may have such a list in mind, or even in hand, but he is sufficiently flexible to order it in any way that seems natural to the respondent and to the interview situation. After all, what does one do when the respondent, while answering the first question, fully answers the third and sometimes questions six and seven? Far from being disorganised by this state of affairs, the interviewer builds upon what has apparently become a shared event. Conversation implies this very property'.

Schatzman and Strauss are quoted at length because they sum up the essential character of the informal interview. This approach, therefore, was chosen not so that the innermost thoughts of the respondents might be exposed, this would indeed be philosophically as

well as methodologically problematic for the researcher; rather it was chosen for its flexibility and potential for allowing unforeseen ideas to be expressed by the respondent.

Hyman (1954) holds that the interview method of social investigation is open to criticism because of the interpersonal situation in which the data are collected. This is necessarily true. If the data are to be readily analysed and compared on a case for case basis, the response must be obtained from fairly uniform questions. Yet, if the data are to be more than superficial, the interviewer must be free to probe around the question until he is satisfied that he has captured the respondent's meaning. Cicourel (1964:74) argues that in trying to make the interview a more precise and reliable instrument of social research, sociologists are trying to achieve several incompatible objectives. He cites several instances of these incompatibilities:

'Standardised questions and answers yet focused and unfocused probes; "good rapport" yet detachment of respondent and interviewer; avoiding role prescriptions and role conceptions that are irrelevant to the data but necessary to complete the interview; assuming that the interviewer's ideology may never affect the subject's responses'.

Cicourel takes his argument further in his reflections on Hyman's work on interview error. He says that the evidence put forward by Hyman, of error present in interviewing by experienced researchers, appears convincing. He goes on to say:

'Conceive of error as evidence not only of low reliability but also of "normal" interpersonal relations; of the ways in which persons come to interpret each other as social objects in the course of social interaction'.

If we insist on regarding the interview from Hyman's standpoint then "error" must be the product of the interactionist approach, as this

maintains that interpretation and determination of each other's meaning occurs between actors. The interactionist argument turns on the very criticism which Hyman levels at the interview, namely the interpersonal situation in which the data are collected.

There is, it would seem, an inherent problem with the interview method which seeks to obtain meaningful, valid and reliable data. This problem stems from the necessary social interaction between interviewer and interviewee. The remarks of Bertrand Russell (1927:30) quoted by Hyman (1954) put the question of interpretation of data into perspective.

'The manner in which animals learn has been much studied in recent years, with a great deal of patient observation and experimentation ... One may say broadly that all the animals that have been carefully observed have behaved so as to confirm the philosophy in which the observer believed before his observation began. Nay, more, they have all displayed the national characteristics of the observer. Animals studied by Americans rush about frantically, with an incredible display of hustle and pep, and at last achieve the desired result by chance. Animals observed by Germans sit still and think, and at last evolve the solution out of their inner consciousness'.

There is a fine balance between basing an interview on a series of ideas and hunches, yet still allowing the respondent to introduce new thoughts and concepts to the study; and allowing the underlying perspective to so dominate the interview that there is no chance of unforeseen topics or concepts being introduced by the respondent. Considerable attention had to be given to the underlying structure of the interview, which is referred to as the agenda. There are several inherent dangers in simply allowing the interview to run its course without any form of directives or guidelines. Schatzman and Strauss discuss the way in which the interviewer must set the pattern for the interview when "the interviewer does most of the leading and the

respondent does most of the talking". Thus the interviewer has an agenda, a selection of topics to be covered during the course of the interview, and must introduce these in such a way that it appears to the respondent that he is free to say whatever he wishes on the subject and, to some extent, to dictate the subject. In other words, although the researcher has a clear aim in mind when using the informal interview, the method must be sufficiently flexible to accommodate new ideas during the course of the research.

The problems of dealing with qualitative data are numerous. The end result of an informal interview must be categorised in some way. This process is considerably less daunting if some strategy is employed during the interview which ensures that the questions are pitched at the right level so that both researcher and respondent have the same frame of reference in their discussion. The art of questionnaire formulation offers several lessons in this area. The main pre-occupation in designing the questions is to ensure that they are unambiguous. In an informal interview questions can always be rephrased, explained, probed in a freer manner than in a questionnaire schedule; nevertheless, some underlying principles of question formulation are worth noting.

Lazarsfeld (1972:193) discussed the 'art of asking why' and put forward three main principles. Although the examples given by Lazarsfeld are connected with market research questionnaires, his essay has some implications for less easily defined substantive areas. His first principle, that of specification, concerns ascertaining what a question means. He points out the dangers of using just one question and taking the respondent's answer at face value; he suggests that

follow-up questions which are more specific will help to solve this problem. The researcher must keep in mind what it is he is trying to find out. The second principle he offers, the principle of division, is probably the most enlightening. In Lazarsfeld's terms it "consists in adapting the pattern of our questionnaire to the structural pattern of the experience of the respondent". This he says is in conflict with the usual procedure. "Traditional opinion is that a question should be so worded as always to insure the same reaction on the part of all those interviewed". Lazarsfeld advocates what he calls 'loose and liberal' handling of the questionnaire and that the question be fixed in its meaning not its wording. This is a particularly helpful point to bear in mind throughout the course of an informal interview. The third principle, that of tacit assumption, is similar to the principle of specification in that it points up, once more, the fact that everything concerned with formulating the questions to be asked depends upon the purpose of the study. The interviewer and respondent must take certain things for granted and proceed from that point. In the market research field, from which Lazarsfeld draws his examples, he says:

'The problem of tacit assumption constitutes such a strong limitation upon the use of questionnaire alone that it is sometimes necessary to resort to a combination of experiment and interview'. (Lazarsfeld 1972:197)

The question of tacit assumption has implications for the informal interview; the interviewer must probe sufficiently to discover, in Lazarsfeld's terms "what the answer means".

Recording the data

The method of recording the interview was considered at some length. The initial reaction of the researcher was to reject the use of a tape recorder because of the problems of transcription and the possibility of inhibiting the students. However, on reflection the advantages of using a tape recorder, the main one being obviating the need for the researcher to take notes during the interview, outweighed the disadvantages. Thus the tape recorder was used in order to facilitate the conversational style of the interview, and to save the researcher the task of hand recording the students' remarks. It is a difficult enough task to follow the respondent's train of thought, allow spontaneity and to cover the points from an agenda without the added task of writing it all down. Lofland (1971) supports the use of a tape recorder in his writings on intensive interviewing when he says:

'One must be thinking about probing for further explication or clarification of what he is now saying, formulating probes, linking up current talks with what he has already said, thinking ahead to put in a new question that has now arisen and was not taken account of in the standing guide (plus making a note at that moment so one will not forget the question); and attending to the interviewee in a manner that communicates to him that you are indeed listening'.
(Lofland 1971:89)

3. TOWARDS THE INTERVIEW - EARLY DAYS

On the basis of a number of group discussions with student nurses, an exploratory questionnaire was drafted and given to a group of twenty student nurses. Exploratory work is generally undertaken in order to give an indication of the outcome of the main study. This work enables the researcher to refine the tools, smooth out any foreseeable

problems of analysis and generally confirm the adequacy of the research design, before embarking on the main study.

In the early stages of this study it was thought that the way in which the nurses' views would be elicited would be twofold; by postal questionnaire with a small number of follow-up interviews. The questionnaire covered three main areas. Firstly, basic demographic details, sex, age, age on leaving school, educational achievements, marital status and residence in or out of hospital property. Secondly, questions about why the respondent became a nurse, expectations of nursing before starting and the respondent's current ideas about nursing. Finally, questions designed specifically to elicit the nurses own priorities in patient care, ideas about the organisation of nursing care and their perceived difficulties in achieving these priorities.

There was a very poor response to this exploratory questionnaire, only five out of twenty were returned. This fact alone pointed to the need for further consideration. The five completed questionnaires did give some indication that the nurses found difficulty in establishing a rank order of their priorities in patient care. Where the questionnaire involved ranking priorities in nursing activity (cf. Anderson 1972) the students had put comments such as 'depends on the situation', 'you can't rank these, they all matter'. This response convinced the researcher all the more of the need to interview. The areas of nursing thought to be important included comfort of the patient; giving reassurance and clear explanations to the patient; taking care of emotional needs.

These data were limited because of the form that the questionnaire took, and particularly by the fact that it was self-administered. It was thought that the information yielded would be fuller if the questionnaire were administered by the researcher. There seemed little point in undertaking that type of questionnaire survey and conducting follow-up interviews. It was therefore decided to develop an interview technique which would elicit the student nurses' views on patient care and their nursing world.

In the time lapse between the exploratory questionnaire being distributed and the return of the completed ones, the researcher was gradually moving towards the idea of using the interview alone, rather than as a follow-up to a number of questionnaires. The poor response rate was, therefore, really only tangible support for a decision that the researcher was already in the process of reaching; that is the decision to ascertain the nurses' views about nursing by means of informal, tape recorded, interviews. A consideration of the literature led the researcher to this conclusion, along with an intuitive desire to adopt a flexible, qualitative approach to data collection.

The grounded theory approach to the study made it inappropriate, in one sense, to undertake a pilot study of the conventional type, that is a "small scale replica of the main study" (Krausz and Miller 1974). Yet the role of the early work in this type of study is crucial; one of the main aims of this work was to give the researcher experience in conducting the interviews and in handling the tape recorder both in the technical and social sense. The other was to arrive at a style of interview that seemed best fitted to elicit the views that nurses had

about nursing care and their nursing life in general.

The study could not be envisaged in advance because of the possibility of the emerging conceptual categories altering the nature of subsequent interviews; therefore, in the strict "small scale version of the main study" sense, a pilot study could not be undertaken. On the other hand, the nature of a pilot study is evolutionary in that one approach is tried and the outcome observed, on the basis of the outcome alterations are made and a second approach tried until a satisfactory method has been adopted. The mechanics of this, that is altering one's approach on the basis of previous findings, are exactly those involved in generating grounded theory. In one sense, therefore, the pilot study was a trial run for the main study, in that the skill of directing the interviewing on the basis of findings from previous interviews was practised.

Thus, the first interviews provided an opportunity for the researcher to gain experience in the informal interview technique; different approaches were tried until the researcher was satisfied that the approach adopted did enable the nurses to express their views about nursing in a spontaneous way. The tapes from these interviews were analysed in a limited way; the tapes were played back in order to ascertain what views were expressed by the student and to begin to conceptualise the emergent themes. The researcher also took particular note of the style of the interview and by processes of trial and error attempted to improve the technique.

Before these interviews were commenced the researcher held a few small group discussions with student nurses in order to see

whether it was possible to get student nurses to discuss their ideas about nursing and its organisation. These sessions were useful largely because they demonstrated that the students were quite forthcoming in their discussion. One group was particularly critical of the college of nursing. This heartened the researcher because one of the main reservations about obtaining the volunteers for interview in the study, through the college of nursing, was the fear that the researcher might be regarded as part of the establishment and this, in turn, might affect the data.

Early interviews

The interviews were undertaken primarily to elicit the views that the students held about nursing. The subject matter of the research can best be summed up by the question - what do student nurses think is important in nursing and how do they see their world. The interview was designed with a view to explaining, as far as was possible, why the students held the views that they did. Certain topics which the researcher thought might be pertinent were included; these topics were arrived at through a consideration of the literature and the researcher's personal experience of nursing.

The interviews were conducted in a conversational style. The researcher started by asking opening questions about why the student became a nursing student and what expectations she had of nursing, prior to starting. After these general opening remarks the researcher tried to get the student to define nursing. Questions such as:

Many definitions have been attempted in order to say what nursing is. If you had to define nursing what would you say that it is?

or:

Do you think that we could try to define nursing,
in your own terms, what does nursing mean to you?

There were then several topics which the researcher either introduced or pursued if the student mentioned them spontaneously. These topics were the organisation of nursing care at ward level, what types of organisation the nurse had experienced and would prefer to work in. The socialisation process was explored by questions concerned with who had influenced the student during training, if she could say how she had acquired the knowledge and skills that she now had. The nurse's views on talking with patients were discussed again, either spontaneously as they arose or if the nurse did not mention communication the researcher introduced the topic in such a way as "what about talking with patients?"

The first three pilot interviews were undertaken with recently qualified staff nurses. This group of nurses was selected purely on a convenience basis in that the staff nurses were contacts of a colleague of the researcher and willing to be involved in the early work. The interview agenda which was used at the first interview consisted of four A4 sheets of questions, with an equal number of sheets providing a checklist on the left hand side of the page. This method of conducting the interview succeeded, it seemed, in setting a formal tone rather than the desired informal nature of the interview. Subsequently the researcher condensed the content of the A4 sheets onto a single small index card. The use of the card was retained throughout the work.

The first three interviews revealed several important points about the researcher's technique. There was a tendency not to probe deeply

enough, or ask 'why' often enough. It seemed that if the question 'why?' had been pursued more vigourously the views of the nurses might have come through more readily. However, it may well be that the nurses would have been unable to answer many 'whys?' Garfinkel's (1967:35-45) work concerning 'routine grounds of everyday activity' is pertinent here. His concern is to demonstrate that society's members experience and know order in their everyday lives because of the taken-for-granted status which familiar scenes in life have. In an attempt to probe the taken-for-granted elements of interaction, his students carried out exercises with friends whereby they probed answers to questions, answers which would in the normal course of events satisfy them. The students found that further probing and questioning in response to what the person being questioned thought to be a perfectly good answer, led to bewilderment and rank hostility. For example:

'Subject: I had a flat tyre.

Experimenter: What do you mean, you had a flat tyre?

(She appeared momentarily stunned. Then she answered in a hostile way):

What do you mean, what do you mean? A flat tyre is a flat tyre. That is what I mean. Nothing special, what a crazy question'.

This extract illustrates the point that if the taken-for-granted element of an interaction is ignored, and one party asks what seems to the other a silly, out of place question, then the stability of the exchange is lost. If the student nurses had been asked 'why' too often by the researcher when they felt they had supplied adequate accounts, the researcher's probing might have proved counterproductive.

The preliminary questions about expectations, reasons for becoming a nurse were not actually producing useful data, neither were they

breaking the ice for the rest of the interview. The question about defining nursing yielded text-book type answers; this was evidenced not only from the answers given but from the way in which the nurses expressed them and the language they used, e.g. "trying to look after people who have some physical or mental illness and trying to support them through their treatment and their illness". The very fact of starting by asking for a definition did set the tone of the interview on something of a question and answer basis, a style which the researcher wanted to avoid in order to allow the students' own ideas and values to come through.

The rest of the early interviews (5 in all) were conducted in rather a different style. A more direct approach was used in the hope that instead of asking subtle, often too subtle, questions, the direct questions would enable the student nurse to reveal her ideas to the researcher. It was decided that the student would be told that the researcher was interested in the views which she held in relation to nursing. In this way the researcher hoped that whatever came out of the interview would be useful, insofar as the nurse had a clear idea of what the researcher was interested in. This preamble was therefore used:

'I am interested in what student nurses think about nursing. The kinds of things I would like us to talk about, from your own experience so far, are - what you think nursing is all about, what views you have on patient care, how nursing is organised - hospital life in general. Perhaps to start with - what matters most to you in nursing, i.e. what do you think is really important in caring for patients'.

The topics covered in the rest of the interview were those covered in the first three interviews. The main difference here was the approach.

The initial outline of topics for discussion seemed to help to set a more informal style. Once the student nurses had given an idea of their views on nursing the rest followed more naturally. The researcher experimented with becoming more involved in the discussion, offering an opinion now and again as a form of encouragement. This appeared to be a successful tactic in that the nurse would volunteer further comment in more of a discussion than an answer to a question.

There came a point in this early work when the researcher felt considerably more at ease with the interview than had been the case at the start. Interviewing is a complex process and in this case a fairly costly one both in tapes and time. Perfection takes a long time to reach (if it ever is reached) and so a fairly arbitrary cut off point was made when eight interviews had been carried out.

The use of the tape recorder had been decided upon before the work began because it was thought that the anticipated analysis demanded its use. The flexibility of the method of data collection necessarily has implications for the mode of analysis. The analysis tactics were difficult to envisage until the data collection was underway, yet they clearly had to be considered in order to reach a decision about recording data. Analysis is more fully discussed in the next chapter. Suffice it here to say that, 'grounded theory', generated from data, requires that analysis takes place alongside the data collection. Because of this it was thought that a full record of the early data would need to be available to refer to for reconsideration during the later stages of analysis. Categories which emerged in the early stages could be reformulated or modified

by constantly referring to the data. An actual recording rather than merely a transcript conveys the flavour along with the content of the interview. The possession of a recording of the interview as well as a typed transcript further strengthens the researcher's claim to the data being more akin to participant observation type data. Also, the fact of having tape recorded data makes it possible to verify any particular point which may arise in the analysis. Fears that the nurses would not be at ease with the recorder were soon allayed. One of the nurses interviewed during the early stages did not feel happy with the recorder and was hesitant for a few minutes, making references to the machine "I hate that thing on, it's really difficult". The researcher offered to turn the recorder off and continue without, but the student preferred to carry on and very soon became more relaxed and fluent and apparently unaffected by the taping.

This experimental stage in development of the interview achieved its main aims. Firstly, giving the researcher experience of the informal interview and secondly, the development of a style of interview which appeared to be successful in eliciting and recording the ideas and opinions that the students held about nursing in a way which rendered the data amenable to analysis. As strict comparability of interviews was not called for, the natural improvement of the researcher's interview technique, as the study progressed, could be accommodated without endangering the research design.

4. ABOUT THE STUDENTS

The data were collected by means of informal interviews with a small number of student nurses. The researcher's aim was to interview a group of student nurses who were willing to discuss their views on nursing in an open and free way. The researcher made the decision to include only those students for whom the current training programme was the first nurse training they had undertaken. This was because the socialisation of the students constituted a research interest. The students involved in this study were included on a volunteer basis and are not held to be systematically sought out, or a representative group. The qualitative approach to the study and the attempt to generate a 'grounded substantive theory' demanded that the interviewees were volunteers; it was their willingness to participate which was the important inclusion criterion rather than any statistically oriented reasons. It was thought that a genuine desire, on the part of the students, to discuss their ideas about nursing was a prerequisite to obtaining worthwhile data.

The data collected were from student nurses from two Scottish colleges of nursing; the students were at three different stages of their three year training. These are described as 'early', 'middle' and 'late' stages, where the terms refer approximately to eight months, eighteen months and thirty months respectively. The students in the 'late' group were in fact in the six month period known as 'pre-registration' - that is to say they had sat their State Final Examinations but had six months experience to gain before becoming Registered General Nurses.

It was decided to approach groups of student nurses, whilst they were in the colleges of nursing attending lectures, in order to explain the research project and to obtain volunteers. Nurse training is organised in such a way that all the nurses in one 'set' (that is in one particular intake) spend spells of time attending lectures in the college (see Appendix 2 for description of training). This timetabling of nurse education made the task of finding a group of students from which to elicit co-operation in the study an easy one. The Directors of Nurse Education of the two colleges of nursing were approached and their permission to proceed obtained. It must be said that the researcher met with nothing but wholehearted and enthusiastic co-operation from all the staff from the Director to the secretarial staff. It was agreed with the tutors concerned that the researcher should approach various 'sets' in order to explain the study and ask for volunteers. This was done over a period of months in order to stagger the interviews and to obtain access to students at the three different stages. In order to distinguish between the groups of student nurses which were approached and those who volunteered and were subsequently interviewed, the former are referred to as the peer group and the latter as the volunteer group.

The two colleges of nursing included in the study were chosen for their proximity and convenience. The researcher had to have fairly easy access to the hospitals in order to carry out the interviews with the student nurses. One college was attached to a city teaching hospital and the other to a large hospital situated some miles outside the city and within a few miles of a new town. As the colleges were chosen for reasons of expediency so were the 'sets' selected on the

basis of criteria which might be described as convenience criteria; convenient in the sense that the particular 'sets' approached were chosen because they happened to be in the college at the time when the researcher was ready to interview. Once the interviews were underway the researcher was able to plan ahead and approach appropriate 'sets' en masse, whilst they were in the college.

Once the 'sets' had been selected, the researcher arranged with the tutors concerned to have a short session with the students in order to explain the study and to ask for volunteers. The researcher explained her work in research to the student nurses and described the present study and her interest in obtaining the views of student nurses by means of informal interviews.

This preamble went along such lines as:

'I am interested in finding out more about what student nurses think about nursing. There is a lot written about what nurses should do and about how nursing should be organised, but more often than not this comes from trained staff. It seems to me that you people are doing a lot of the nursing and it would be a good idea to find out what you think'.

This introduction invariably met with laughter after the suggestion that the researcher was interested in what they thought of nursing. There was general agreement upon the fact that they did much of the work. The researcher then went on to say something like:

'The interviews will be very informal, I have some topics I want to talk about but mainly I'm interested in finding out what you think is important and following up your topics. I'd like to tape the interviews, simply so that I don't have to sit and scribble whilst we talk; I know they can be a bit off-putting at times, but I'm the one who will be playing them back, and I hate hearing my own voice'.

This part of the 'sell' met with a mixture of interest and reticence. The latter seemed to be largely due to the fact that the students were not sure that they would have anything to say. Sometimes they asked "what sort of questions will you ask?" whereupon the researcher reiterated that it would be more like a conversation than anything but that "we might start with something like - what do you think is important in caring for a patient?"

Questions were invited from the students and then volunteers asked for. The majority of the 'sets' were female and after two had been approached and only two male students volunteered, the researcher asked for female volunteers only, explaining to the men that as numbers were so small, a single sex sample was being sought. In practice most of the men would have been excluded by virtue of the fact that they had, for the most part, already one nursing qualification in psychiatry and the students selected for this study had to be undertaking nurse education for the first time. At the outset it was not clear how many interviews would be required; the data were allowed to direct this decision. However, some guideline was needed if interviewees were to be sought. A fairly arbitrary figure of fifty was settled upon and it was estimated that out of each 'set', which ranged between 16 and 30 students, about one third could be expected to volunteer. In order to obtain a sufficiently large number of nurses from which to draw the volunteer group, one 'set' in each of the 'early', 'middle' and 'late' stages was approached in each of the two colleges. That is to say, 155 student nurses were approached, 56 volunteered and 40 were eventually interviewed. In the later stages of the study the researcher had a list of potential interviewees from

the original 56 who had for one reason or another been unavailable for interview earlier. Some volunteers had said at the outset "get in touch when you want to interview me", or "I'll put my name down and you contact me". This flexibility was ideal for the study method as later interviews were very much directed by earlier ones and it was convenient to have a group of potential interviewees available when required. In order to maintain interest in the study the researcher wrote periodically to all the volunteers either to make appointments, give a very general idea of the progress and to give notice of an impending request for an interview.

This method of data collection was necessarily very flexible because of the approach of the study. It was difficult at times to maintain some order in the data collection schedule, whilst keeping abreast with the analysis and maintaining the student nurses' interest. Small numbers made this task easier than it might have been and the informality, which the researcher tried to maintain, did, in the long run, bear fruit in terms of the data obtained.

The volunteers

The 'volunteer' group drawn from the two colleges was distributed as shown in Table 1.

TABLE 1 Distribution of the volunteers between colleges

| | <u>Early stage</u> | <u>Middle stage</u> | <u>Late stage</u> |
|-----------|--------------------|---------------------|-------------------|
| College A | 4 | 5 | 8 |
| College B | 5 | 10 | 8 |
| Total | 9 | 15 | 16 |

As it has been stated, the group of student nurses interviewed in this study is not held to be a representative group. This 'sample' was obtained for interview in the spirit of Glaser and Strauss' (1967) 'theoretical sampling' and not in any statistical sense. Although there was never an intention to generalise from the 'volunteer group' either to the 'peer group' from which the student nurses selected themselves or beyond, it was felt that some means should be found of determining if there were any obvious reasons why the 'volunteer' group might have produced possibly atypical data. Thus, the 'peer' group and the 'volunteer' group were compared on a number of variables in order to determine whether or not the nurses in the 'volunteer' group were demonstrably different from their peers in ways other than their desire to volunteer for inclusion in the study. In short, the nurses interviewed were compared on the demographic variables age and educational achievement, with the peer group from which they had volunteered. Although the volunteers, by definition, were not selected by any recognised sampling method which would enable the results to be generalised to a wider group of student nurses, the data are intrinsically worthwhile because they represent a freely given account of the student nurses' world.

The data were collected from the college records for all the student nurses, both the 'peer' group and the volunteers. Permission to do this was obtained from all the students when the study was first explained to them. These data were analysed using the Statistical Package for the Social Sciences (1975). This was thought to be an appropriate means of analysing the data even though the numbers were small. Because the data had to be coded and set up for analysis in

some way and the availability and ready usage of the statistical package made it an obvious choice. It was thought that non-parametric tests would be the most appropriate for the type of analysis required here. Non-parametric tests demand no assumptions to be made about the shape and distribution of the population and are thus more suited to this rather unsystematic data set than are their parametric counterparts.

In this study the Mann-Whitney U test was employed in order to determine whether there was any difference, in terms of age and educational achievement, between the group of student nurses interviewed and the peer group from which they volunteered.

The student nurses who volunteered were in the main between the ages of $17\frac{1}{2}$ and 22 years. There was a small number of mature students within the entire group approached (the 'peer' group and 'volunteer' group); some of these students had already studied nursing and were State Enrolled Nurses, others had considerable experience as nursing auxiliaries. The study was explained in such a way that it was apparent to these mature students that it was students who were relatively new to nursing that were being sought for interview. Hence the mature students did not volunteer.

The mean age of the 'volunteer' group was very similar to that of their 'peer' group; the scatter, however, was more marked in the 'peer' group.

TABLE 2 Mean age for all student nurses by group

| | <u>Volunteer group</u> | <u>Peer group</u> |
|----------|------------------------|-------------------|
| Mean age | 18.9 | 19.8 |
| S.D. | 1.9 | 4.7 |
| n | 40 | 115 |

When the students over 30 years are discounted the groups become more homogenous.

TABLE 3 Mean age for student nurses under 30 years by group

| | <u>Volunteer group</u> | <u>Peer group</u> |
|----------|------------------------|-------------------|
| Mean age | 18.9 | 18.7 |
| S.D. | 1.9 | 1.7 |
| n | 40 | 108 |

The similar mean ages of the volunteer and peer groups is thus accounted for by the fact that there were more students in the peer group and that the seven mature students (over 30 years) were among the peer group. Neither the Mann-Whitney U nor the T-test revealed any significant differences between the volunteer and peer groups in terms of age.

TABLE 4 (1) Educational achievement of all student nurses by group

| | <u>Volunteer group</u> | <u>Peer group</u> | <u>Total</u> |
|----------------------------------|------------------------|-------------------|--------------|
| Mean no. of 'Highers' | 1.8 | 2.1 | 2.1 |
| Mean no. of 'O' grades or levels | 5.5 | 4.3 | 4.6 |

The Mann-Whitney U test was employed in order to determine whether there was any statistically significant difference in terms of educational achievement between the two groups. The only finding which approached significance was the difference between the mean number of 'O' levels possessed by each group. This difference was found to be significant at the 0.005 level of confidence. Although the 'peer' group had a greater number of 'Highers' certificates (in terms of the mean) this finding, whilst worthy of note, was not significant. The frequency of occurrence of other qualifications was too small to comment upon in terms of differences between the two groups.

Thus the only demonstrable difference between these two groups, the 'volunteer' and the 'peer' group, was that the 'volunteer' group had significantly more 'O' level certificates than their peers; whereas the student nurses in the 'peer' group had more 'Highers' certificates than those in the 'volunteer' group. This finding is encouraging insofar as it allays the fear that the 'volunteer' group might have proved to be the more able and possibly more articulate and

(1) 'Highers' refers to the Scottish Certificate of Education (S.C.E) Higher grades. Scottish 'O' grades in the S.C.E. and English Ordinary Levels in the General Certificate of Education are classed together here.

thus atypical group. The statistical tests employed here demonstrate that there was no obvious difference in the academic abilities of the two groups. It is, however, interesting to speculate, in passing, on this finding. It could be that the bright students, with a strong motivation to nurse - 'vocational group' - attain good 'O' levels yet once they are eligible to enter nurse training they are willing to leave school before taking Higher certificates; the suggestion being that becoming a nurse is of more importance to them than attaining academic standing. Whilst those who stay on to do their Higher certificates come to nursing with a different motivation. The eagerness of the 'O' level group to start nursing, could have been reflected in their keenness to discuss nursing with the researcher. A number of the 'volunteer' group did state at interview that they had left school just weeks before they should have taken their Higher examinations; the reason given was that they had been accepted by the college of nursing to join the next intake; once this offer came they had no further interest in educational advancement in any area other than nursing.

5. DOING FIELDWORK

This discussion is offered in order to convey some feel for the interviews and hence, the study as a whole. The intention is not to describe the content, although passing reference is necessarily made where appropriate, but rather the way in which the interview happened. When data are obtained by means of an informal, conversational style interview the researcher's approach and setting up of the situation is

as important as, and indeed one could argue almost more important than, the questions asked.

Approaching the students

The researcher was anxious to present herself to the students as someone outside of the hospital organisation and with nothing to do with the college of nursing. It was felt that any perceived links with the 'establishment' might affect the nature of the data obtained. It was, of course, necessary to indicate where the researcher was based and although it was felt that it would suffice simply to say "from the University of Edinburgh" to the students, the researcher considered that the point of entry (the staff of the college of nursing) would require more detailed information. It was also thought that the students might find the interview easier to handle if they knew that the researcher was herself a nurse. Thus, introductions were made always by the researcher saying that she came from the Nursing Studies Research Unit at the University of Edinburgh. Having said that, it was always possible to shift the emphasis depending upon who was involved. Thus, the nursing research angle was stressed with the college staff, whereas several of the students, who showed an interest in the study, were freely told that the researcher was writing the study up as a postgraduate thesis. This often stimulated a feeling of comradeship in the "we are all students together" sense. This, in turn, helped to create the informal atmosphere that was thought to be desirable for the interview.

The fact that the researcher had decided to approach the student nurses through the college in the first instance did put the research on a fairly formal footing from the start. The tutors were, as

individuals, very friendly towards, supportive of, interested in and helpful to the researcher. The study was discussed with each tutor whose students were to be approached and asked for their help in the study. However, when it came to the tutor introducing the researcher to the groups of student nurses they tended to do so in a formal way using 'Miss' as the prefix to the surname (although the researcher never introduced herself in this way) and managing to convey to the class that the forthcoming short session with the researcher was a compulsory event: in doing this the tutors seemingly destroyed any hope of informality.

This is, at one level, a trivial point but as the researcher had only twenty to twenty five minutes in which to 'sell' her study and obtain volunteers it was crucial that barriers should not be put up between her and the students. Having anticipated this sort of difficulty, the researcher always arrived for these occasions in smart, but casual, clothes and tried not to appear to be anything which might be described as 'establishment' in the world of nursing. Once the tutor left the room, the researcher re-introduced herself using her Christian name and stressed the fact that she was grateful to the students for their collective ear and, after a very brief description of the study, invited anyone who was not interested and might have other things to do to feel free to leave.

The students were, by and large, interested and willing to help. Even those who said that they did not wish to be interviewed were curious about the study in terms of what sort of topics the interviews covered, how would the data be handled and would there be any feedback. Volunteers were a little slow to materialise initially on each occasion

that the researcher approached groups of students. However, once one or two gave their names as volunteers the rest followed. The group to begin with provided a pressure which discouraged volunteers. Had the researcher put the question the other way round and asked who was not interested, she might well have obtained a larger number of volunteers. This was never considered seriously as a strategem; it is mentioned simply as a comment on the role of group pressure in the quest for volunteers. In order to ease this process, the researcher did not remain at the front of the classroom, but moved among the students taking names and addresses, sometimes making dates, other times exchanging telephone numbers. In this way it was hoped to establish some rapport with the students and to implant the idea of informality before ever the interviews began. At the end of this short session with the students the researcher thought that the general feeling of the students was one of friendly interest which bode well for their future co-operation.

The interviews

Once the students had volunteered to take part in the study they contacted the researcher at their convenience and an interview was arranged. For the most part the interviews took place in the flats of the student nurses or in their rooms in the nurses' residence. The rest were carried out either in the tutorial rooms in the college of nursing, or on several occasions in the researcher's flat. Apart from the interviews held in the tutorial rooms (six in all) the interviews were conducted over coffee. This helped to produce an informal atmosphere and detract attention from the tape recorder. It also was gratifying for the researcher to feel so welcomed by the students; the

gesture of the coffee put the encounter into an informal social context.

Although the researcher had gained some experience in interviewing during the first 'trial runs', there was obviously still room for further improvement as the study progressed. As in the early attempts at interview, the researcher took into each one a card on which her main prompts and opening questions were written; also a notepad which was used to make a note of anything said during the interview which she wished to return to but did not want to interrupt the flow at that time. Both of these aids were explained to the student so that they did not destroy the conversational nature of the interview. That is to say, the researcher explained that, whilst her main intention was to ask the student what were her views on nursing and to discuss what the student thought was important, she did have an agenda. The notepad was justified with a remark such as, "don't let it put you off if you notice me scribble down the odd word as we go along, it is just in case you say something that I want to come back to and I'm likely to forget if we get onto another topic meanwhile". The need to use a tape recorder had been explained right at the start when the researcher first approached the students in the college of nursing, and no objections had been raised. The researcher confirmed with the students that its use was acceptable before starting the interview.

Before the tape recorder was switched on the researcher reiterated the purpose of the study and emphasised the fact that it was a conversational style interview and that she was particularly interested in the views that the students had, rather than to get through a list

of pre-determined questions. This was made clear by the researcher saying something like "This isn't going to be a question and answer, Robin Day-type interview, but much more of a conversation. I'm interested in what you have to say and we can take it from there".

The researcher used the period of time whilst she was setting up the recorder to put the student at ease for interview; this time often coincided with the student making coffee. Thus, this dual activity of looking for sockets, enquiring about milk and sugar and boiling kettles gave both participants in the forthcoming social encounter something concrete to do whilst breaking the ice and establishing a rapport. In order to ease the way into the interview the researcher always told the student that she would repeat her opening remarks into the tape recorder as soon as it was switched on so that the student did not have to start, as it were, cold. Thus the researcher after some general remarks would say something along the lines of - "What matters to you most in nursing - what do you think is really important in nursing?"

There was some inconsistency in the last part of the opening question in that the researcher sometimes added the word 'care' which tended to focus the discussion into the patient care aspect of nursing. Although, even if the word 'care' was included the preceding preamble indicated to the student that the researcher was interested in what aspects of nursing meant to them. Most of the students started to reply in terms of patient care however the opening question was phrased.

For example, "Looking after the patient, thinking of the patient as a person" (7). (1) "To get the patient comfortable, make him feel as comfortable as possible" (14). Other ideas were sometimes introduced immediately, for example, one student said:

'Basic nursing care of the patient is important, to achieve this you must have a very well organised system - so everybody knows what they are doing. You can't have people looking after people properly unless they do know what is going on and what they are supposed to be doing'. (8)

This student focused the interview on one of the topics of the agenda, that is organisation at ward level and so led the interview into that area without the researcher having to direct the conversation.

Similarly another student placed the emphasis from the start on the position of the student nurse in the ward hierarchy when she said:

'I think more could be done for patient care - student nurses should have a little more say'. (13)

Yet others focused on the social aspects of the work and started the discussion in terms of job satisfaction.

'Meeting people, mixing with them you never go in and have two days the same - you'd never get that in an office'. (23)

If the opening question did not meet with any response the researcher was obliged to expand upon it and fill the potentially embarrassing silence; so early on in an interview it was felt that a silence could be off-putting for the student. Although later on there were quite natural pauses when the student tried to gather thoughts, or think of an example. During the later stages it seemed that the student had

(1) Figures in brackets, throughout the text, show the code numbers of the interviews.

virtually forgotten that the tape recorder was on and so pauses were less difficult to handle than was the case at the outset.

As the interviews progressed the researcher became more au fait with the agenda and found that she could remember topics which were touched upon at an early stage in the interviews and return the student to the topic via another route much later in the interview. As this ability developed so did a true conversational style. Some students were, by the nature of things, more responsive at interview than others. There was a tendency for some to give fairly limited answers and any attempts to probe further often passed by without success. In most cases short answers were expanded if the researcher prompted with "why?" or "how was that?" or "can you tell me just how you mean?" etc. Such probing was undertaken with sufficient caution so as to preserve the natural conversational style and not to antagonise the student (cf. Garfinkel 1967).

As the researcher became more at ease with the agenda and the interviewing technique itself, she began increasingly to offer an opinion in the interviews and at times the discussion became quite animated. Sometimes, and especially if the student was clearly comfortable with her opinions, the researcher would either play devils advocate or put forward an argument and ask what the student thought about it. This, in the more conceptual and articulate students, often provoked a response which furthered the discussion and elicited their opinions on the matter. Other students tended simply to agree with the researcher or say, as one student did, "yes, I'd never thought of that but you are right".

Provided that this mode of eliciting data is treated with caution it is useful, as the researcher learned during the course of these interviews. Clearly, if the acquiescence of the student is taken to be synonymous with the student having independently volunteered the opinion with which she simply agreed, this would be an abuse of the technique. If, on the other hand, such an argument put forward by the researcher led to useful data and an independent furthering of the argument by the student, use of such data is a different matter.

The ideas that students raised in one interview could be tested out during later interviews if the opportunity presented itself or if the researcher felt that it was a point which she wanted to develop. This progression from one interview to the next is very much in the spirit of 'grounded theory generation'. The testing of hypotheses and search for negative cases, advocated by Glaser and Strauss (1967) was carried out in this more rigorous follow up in the later interviews of themes which emerged in the earlier ones. The fact that the researcher was becoming increasingly familiar with the data and the method enabled this progression to take place. Much of the skill in this area lay in quick thinking on the part of the researcher so that points which were potentially relevant to developing categories could be picked up and developed as the students raised them. The mental acrobatics involved confirmed the researcher's belief that Lofland (1971) was right in advocating the use of a tape recorder.

At the end of the interviews the researcher was convinced of two things. Firstly, that the use of a tape recorder was an imperative in this study. It did not cause any problems for the students, most

of them, when asked afterwards, said that it hadn't hindered them, indeed many ceased to think about it after a few minutes. Secondly, that the conversational style interview did seem to be an appropriate means of getting students to talk about what they considered to be important in nursing.

Having taken one course of action in a study it is only possible to speculate about how the method stands up against other alternatives. Nevertheless, it does seem reasonable to suppose that any more structured a method would not have yielded the kind of data obtained by the informal interviews. The researcher would not have opened up some of the areas which were eventually covered had the interview been more pre-determined. It seems certain that the range of data and the opportunity to follow certain lines of enquiry and to drop others would not have been afforded by a more directed approach.

PART TWO

CHAPTER 4

Strategies for analysis

This chapter is concerned with the procedures employed in the analysis, rather than the outcome of the endeavour. The work of Schatzman and Strauss (1973) is drawn upon extensively. Their discussion of 'note' making was of particular use in the analysis of these data, not least because of the simultaneous collection and analysis of data which the method entails. This approach rules out the possibility of pre-determined techniques of analysis, as Schatzman and Strauss (1973:108) put it:

'Qualitative analysts do not often enjoy operational advantages of their quantitative cousins in being able to predict their own analytic process; consequently, they cannot refine and order their raw data operations built initially into the design of the research'.

The analysis is, therefore, a process which is bound up with the data collection. The data are treated then as an accumulation of information which is constantly being updated and elaborated, rather than a collection of data to be analysed later. Analysis is a lengthy, continuous process where each stage builds upon the last and towards the next so that a well integrated report of the data is the end product.

Schatzman and Strauss (1973:109) discuss strategies for a natural sociology in a work in which they deal with Field Research. They state that:

'Some researchers are satisfied to deal with uncoded anecdotal data and depend almost entirely upon the fortuitous development of insight; at the other end of the spectrum are those who laboriously codify their data and apply more systematic analytic techniques, including statistical ones, to arrive at social theory'.

The approach used in this study was a balance between these two extremes. However committed one is to the qualitative method, it is inevitable that a certain amount of classification and coding will be carried out if the data are to be analysed and some meaningful interpretation communicated to others. There is no detraction from the qualitative approach inherent in classification. The essence of the method lies in the way in which the data are collected, analysed and interpreted.

Approaches to qualitative data

Before describing the strategy employed in handling the data, a review of techniques used by others, who have been faced with unstructured qualitative data, is offered in the form of a short account of some approaches to the problem. Barton and Lazarsfeld (1955) ⁽¹⁾ addressed the question:

'What can a researcher do when confronted by a body of qualitative data - detailed, concrete, non-metric descriptions of people and events, drawn from direct observation, interviews, case studies, historical writings, the writings of participants?'

In order to answer this question they looked at one hundred studies in order to describe the most characteristic types of qualitative work. In doing this they begin by discussing the value of the simple observation, progress through these studies which classify data, to those in which several variables are inter-related through qualitative analysis. Finally, research where the analyst, in trying

(1) Barton and Lazarsfeld in McCall and Simmons (1969), pp.163-196.

to encompass a great number of dimensions without making each explicit, sums up a general pattern; this, argue Barton and Lazarsfeld, is:

'The point at which qualitative research is most creative, most controversial and most difficult to describe'.

The role of qualitative data in the support of theory is touched upon. Barton and Lazarsfeld discuss the phenomenon of the "surprising observation", they say that frequently observations are made which are outwith the researcher's expectations. The importance of the "surprising observation" they say, is that it can raise problems for investigation. A well known example of a problem raising observation was the surprising finding of Roethlisberger and Dickson (1939), in the studies at the Hawthorne Electric Company Plant, that experimental changes in the physical work conditions did not account for the increase in production in the observed group of workers. When Roethlisberger and Dickson investigated this surprise finding, it led to their describing the 'Hawthorne Effect'. Barton and Lazarsfeld say that:

'The ability to take a commonplace fact and see it as raising problems is important because it can lead ultimately to such enlightenment'.

Single qualitative observations can also be useful because they can indicate some large scale phenomenon which cannot be perceived directly. Barton and Lazarsfeld cite three types of situation where particular attention is paid to qualitative indicators. Two of these are mentioned here as they are pertinent to this study. Firstly, "situations in which simple qualitative observations are used as

indicators of the functioning of complex social structures and organisations, which are difficult to subject to direct observation". Secondly, situations in which "qualitative evidence is used to get at psychological data which are repressed or not easily articulated - attitudes, motives, assumptions, frames of reference etc." They cite Stouffer's "The American Soldier" (1949) as an example of an indicator of the functioning of complex organisations. Barton and Lazarsfeld state that:

'Wanting an indicator for the complex notion of the "army caste system" pointed to an institutionalised symbolic act: enlisted men selected for officer candidate school were first discharged from the army and then re-admitted in their new and very different status'.

Barton and Lazarsfeld point out that the extent to which the interpretation of indicators remains an art or, to what extent it can be made a science is an important problem for qualitative research.

The two uses of qualitative indicators described above were thought to be pertinent to the present study. The interviews were designed to tap precisely these sorts of areas which are difficult to observe; namely, nurses' views concerned with the practice of nursing and the complex social and organisational structures within which the nurses operated.

Barton and Lazarsfeld address the problem of classification and use of categories; they describe the types of descriptive systems as ranging:

'From crude lists of "types", each defined individually without clear logical relationship to others, to fully systematic typologies in which each type is a logical compound of a small number of basic attributes'.

They go on to say that:

'Classifications near to the unsystematized end of the continuum, preliminary classifications, should not be underestimated as they represent the first step toward the ideal fully systematic classification. Until the data are ordered in some way, the analysis of relationships cannot begin, more refined categories normally develop out of the attempt to analyse relationships between preliminary categories; there is an interacting process between refinement of classification and the analysis of relationships'.

Lengthy quotations from Barton and Lazarsfeld are employed here because they so aptly and clearly spell out the process under discussion. In their estimation a 'good' preliminary classification must provide:

'A workable summary of the wealth of elements in the original data and include - even if in unsystematic form - the basic elements necessary for understanding the situation'.

They suggest that good examples of classifications, unsystematised but fruitful, can be found in the work of the Chicago urban sociologists (Park and Burgess 1921, Thrasher 1928).

The possibility of qualitative data being analysed in such a way as to suggest relationships between two variables is discussed by Barton and Lazarsfeld. They point to the well accepted fact that the existence of a relationship between two variables can only be demonstrated in a cause and effect fashion by controlled experiment or by statistical analysis of a sufficiently large number of cases. They do, however, argue that research based only on qualitative descriptions of a small number of cases, can nonetheless play the important role of suggesting possible relationship, causes, effects and possibly dynamic processes. They, in fact, go so far as to say:

'It can be argued that only research which provides a wealth of miscellaneous, unplanned impressions and observations can play this role'.

Analytic induction

Qualitative research, as described above, is seen in terms of its potential for developing the hypotheses for future research. However, not all sociologists would limit the interpretive method in this way. Znaniecki proposed the method of analytic induction in 1934. On the basis of a small number of cases, appropriately examined, he maintained that a hypothesis could be tested; with the provision, and it is a crucial caveat, that no negative cases are present. Znaniecki (1934) claimed that this was the true method of the physical sciences and should be that of the social scientists too. Analytic induction, he said, could lead to exhaustive knowledge of the situation under study and to causal laws.

'What sociologists should do is this: first, discover what characteristics in a given datum of a certain class are more, and which are less essential; secondly abstract these characters, and assume, hypothetically, that the more essential are more general than the less essential, and must be found in a greater variety of classes; thirdly, test this hypothesis by investigating classes in which the former and those in which the latter characters are found; fourthly, establish a classification, i.e. organise all these classes into a scientific system based on the functions the respective characters play in determining them. This would be a proper analytic induction in full'.
(Znaniecki 1934:259-60)

Robinson (1951), in a discussion of analytic induction, puts one of the claims of Znaniecki succinctly thus: "he holds that analytic induction gives us universal statements of the form All S are P, instead of mere correlations to which there are always exceptions".

Cressey (1950) explains the process of analytic induction as a research procedure in this way:

'(1) A rough definition of the phenomenon to be explained is formulated. (2) A hypothetical explanation of that phenomenon is formulated. (3) One case is studied in the light of the hypothesis with the object of determining whether the hypothesis fits the facts in that case. (4) If the hypothesis does not fit the facts, either the hypothesis is re-formulated or the phenomenon to be explained is re-defined so that the case is excluded. (5) Practical certainty may be attained after a small number of cases have been examined, but the discovery by the investigator, or any other investigator of a single negative case disproves the explanation and requires a re-formulation. (6) This procedure of examining cases, re-defining the phenomenon and re-formulating the hypothesis is continued until a universal relationship is established, each negative case calling for a re-definition or re-formulation'.

The production of a theory which has universal application and takes the form of causal law is rare, if not absent, in social science. Explanations of data in universal, causal terms hold true only for specific social contexts. The question of defining the phenomenon to be explained and constructing a hypothetical model, in order to explain it is taken up by Becker whose work provides some useful insights into the handling of qualitative data. In a paper, "Problems of Inference and Proof in Participant Observation" (1958), Becker describes the "basic analytic operations carried on in participant observation". The paper concerned with inference and proof is helpful because Becker deals with analytic operations carried out upon qualitative data and, the reporting of the results of such analysis. The problem of a mass of unstructured, qualitative data is common both to participant observation studies and the present one. Becker distinguishes three distinct stages of analysis conducted in the field and a fourth stage, which is carried out when the fieldwork is complete. The first three stages he describes as:

'The detection and definition of problems, concepts and indices; the check on frequency and distribution of the phenomena; and the incorporation of individual findings into a model of the organisation'.

The fourth stage of analysis, according to Becker, "involves problems of presentation and proof".

It is the first of the four stages which is taken up here. In the selection and definition of problems, Becker says that the researcher:

'Looks for problems and concepts that give promise of yielding the greatest understanding of the organisation he is studying and for items which may serve as useful indicators of facts which are harder to observe'.

Typical conclusions from data, he argues, are that such a phenomenon exists, or that two phenomena were observed to be related in one instance. Although this conclusion says nothing about the frequency or distribution of the observed phenomena, Becker argues that:

'By placing such an observation in the context of a sociological theory, the observer selects concepts and defines problems for further investigation. He constructs a theoretical model to account for that one case, intending to refine it in the light of subsequent findings'.

This stage of analysis, as identified by Becker, has some promise for the present study in that it offers a way of gradually building up a theory which might explain the data in terms of why students held certain views and how they were able to accommodate these views in their lives as student nurses.

Constant comparative method

Glaser and Strauss (1967:39-40) offer their constant comparative method as an alternative to analytic induction in order to arrive at a theory grounded in data. They maintain that Znaniecki's (1934) analytic induction is concerned with the generation and proof of theories which account for specific behaviour. The theory, thus arrived at, is confronted with negative data and re-formulated accordingly. The constant comparative method, Glaser and Strauss point out, is intended to generate and suggest, but not test hypotheses; it does not insist on universality or proof.

'Generating hypotheses requires evidence enough to establish a suggestion - not an excessive piling up of evidence to establish a proof and the consequent hindering of the generation of a new hypothesis'.

The method adopted for this study resembles that of the constant comparative method. As the categories emerged items of data were examined in relation to the category in order to see if they could be included. Negative data were found and discussed and modifications to categories made accordingly. The method could not be said to ape analytic induction, however, as there was no "hypothetical formulation of the phenomenon" which the method demands. This was absent because the themes of the study developed gradually from its very open beginnings.

Two further sources of literature are offered here in order to set out two rather different ways of handling qualitative data. The work of Knafl and Grace provides a fairly structured way of handling interview material; whereas Schatzman and Strauss discuss strategies

for making sense of field notes.

Knafl and Grace (1978:16-20) in a study - "Families Across the Life Cycle" used a symbolic interactionist framework in order to "uncover then communicate the world view of the various family members we have been studying". They based their approach on the work of Glaser and Strauss (1967) and "began investigations with rather broad research questions and objectives in mind". The researchers involved in the studies in "Families Across the Life Cycle" carried out tape recorded interviews, using interview guides. They describe their method thus:

'We studied data from specific interviews, seeking to identify the key issues or categories, the components of these issues and the relations between these issues. We were then able to generate a rudimentary theoretical model of some process'.

They transcribed the interviews, checked them for accuracy against the tapes and once several were accumulated the development of coding categories began. These categories became the major components of their emergent theoretical models.

'In order to develop such coding categories, we read a sample of completed interviews and formulated what we believed to be major conceptual themes in the specific process under consideration. These tentative categories were then applied to a second sample of interviews and revised in order to take into account any data not covered by the initial categories'.

Their final interpretation of the data:

'Typically began with the analysis of individual coding categories and progressed through the formulation, evaluation and integration of hypotheses'.

The work of Knafl and Grace is mentioned here because they do explicitly recognise that the approach taken in their study was the one propounded by Glaser and Strauss (1967). They describe the use of "qualitative sort cards", cards which represented individual respondents and were punched to correspond to the number of coding categories which applied to the respondent; these cards also contained the comments made by the respondent which appertained to the punched categories. With the data thus ordered, Knafl and Grace were:

'Able to consider all the data on a given category as well as look at the relationships between and among categories'.

It would seem that Knafl and Grace managed to find a balance between reducing respondents' comments to a series of unyielding categories, as can be the case with the coding of open-ended data; and leaving the data in an informal state from which to make inferences and generate theory. However, it must be borne in mind that the 'interview guides' used in their study were fairly uniform and therefore, the data possibly lent themselves more readily to codification of this kind.

'Theoretical notes'

A more flexible method of handling the interview data is suggested in the work of Schatzman and Strauss (1973). The present study drew heavily upon their work and for this reason a fairly lengthy discussion of it follows. Schatzman and Strauss deal with Field Research and offer what they term "strategies for a natural sociology". The authors stress that it is not a "how-to handbook" but that they have written with a focus on the researcher.

'Thus the field researcher is depicted as a strategist; for without linear - specific design - for the most part precluded by the natural properties of his field - the researcher must develop procedure as he goes'.
(Schatzman and Strauss 1973:vii)

The work is organised in terms of strategy for entering; getting organised; watching; listening; recording; analysing and communicating research. The focus of this present discussion is on strategies for recording and analysis.

Schatzman and Strauss distinguish three types of notes that the researcher might make; these are "observational notes", "theoretical notes" and "methodological notes". Their discussion relates to field research where the predominant method of data collection is participant observation and thus "observational notes" are defined as "statements bearing upon events experienced principally through watching and listening. They contain as little interpretation as possible and are as reliable as the observer can construct them". Each "observational note" should stand by itself insofar as it can be understood as an element of the data.

If the researcher wishes to go further than the "facts", he writes, according to Schatzman and Strauss, a "theoretical note". These are inferential notes with "represent self-conscious, controlled attempts to derive meaning from any one or several 'observational notes'". The researcher makes an interpretation of the observation which he feels could have some conceptual future. In Schatzman and Strauss' (1973:101) words:

'He interprets, infers, hypothesizes, conjectures, he develops new concepts, links these to older ones or relates any observation to any other in this presently private effort to create social science'.

A "methodological note" is a note which relates to the research strategy rather than the substantive area under study:

'A methodological note is a statement that reflects an operational act, completed or planned: an instruction to oneself a reminder, a critique of one's own tactics'.

Schatzman and Strauss sum up the role of a methodological note rather neatly when they say that:

'Methodological notes might be thought of as observational notes on the researcher himself and upon the methodological process itself'. (Schatzman and Strauss 1973:101)

This form of note making was thought to have potential for the present study, in that it offered a means of ordering the data from the informal interviews. The "observational notes" were the actual interview transcripts; which consisted of either verbatim or paraphrased sections of the interview (both forms are mentioned explicitly by Schatzman and Strauss). The "theoretical" and "methodological" notes were formulated in the way Schatzman and Strauss describe.

Schatzman and Strauss also describe a means of relating the three types of notes. They cite, as an example, the case where a researcher has made "observational notes" on several occasions on the same phenomena he may write a "theoretical note", possibly discounting the phenomenon as commonplace, or tentatively explaining it: alongside this he may make a "methodological note" reminding himself to carry out some analytic procedure relating to the observational and theoretical notes. As a result of this, he may write another "theoretical note" of his 'findings'. The recording of notes can therefore be seen to be a vital part of the formulation of theory, grounded in the data.

'Packaging' is another useful tactic which Schatzman and Strauss (1973:102-103) describe. This, they offer as a means of handling the large volume of data and interpretations that the researcher produces, especially in the early stages. The need for ordering the data into a system which facilitates information retrieval at a later date:

'For whatever he may be saying about his experiences now, he knows that later they may be conceptually transformed, as new categories emerge in his thinking. Then he will find it necessary to make "analytic searches" for the older items to bring them to bear on the emergent ones'.

'Packaging' is then, a method of ordering the data which facilitates storage and retrieval:

'A "package" of data is an abstract rendering, in brief paragraph form (a half dozen sentences or less) which tells of a single, distinct event (observational note) draws an inference (theoretical note) or makes a tactical decision (methodological note). The package is so prepared as later to be scanned and comprehended at a glance'.

Analysis tactics

Each interview was recorded on a cassette tape and so at the end of the field work the researcher had forty tapes each lasting between 45 minutes and 1 hour. The first stages of transcription were started as soon as was possible after the interview. Bearing in mind the strategies of Schatzman and Strauss, the researcher listened to the tape, jotting down the main themes of the interview and making some preliminary theoretical notes. This note making was done in a spontaneous way at the first hearing of the tape so that the ideas and beginnings of conceptual categories could emerge freely.

The second playing of the tapes was carried out in order to transcribe the interview. The researcher made her own transcripts (although at a later stage sixteen of the tapes were re-transcribed verbatim by an audio-typist). It was not considered that every word of the interview need be written down and so the transcript consisted of a mixture of shorthand terms for the researcher's questions, summaries and verbatim accounts of the student's contribution and theoretical notes. The actual process of transcribing the tapes was a tedious, yet curiously rewarding business. The fact of having to sit and transcribe rather than being presented with a fait accompli forced the researcher to begin to look at the interview in an analytic way from the start. Lofland (1971:91) said of this analytic procedure:

'Transcribing tapes is a chore. But it also has an enormous virtue. It requires one to study each interview. Listening to the tape, piece by piece, forces one to consider piece by piece whether he has accomplished anything in the interview or not. It stimulates analysis, or at least this is the proper frame of mind to adopt when putting the interview down on paper'.

Lofland (1971:91) also advocates the inclusion in the transcript of "a distinction, concept or an idea" as they occur to the researcher.

This is consistent with the "theoretical notes" of Schatzman and Strauss.

The transcripts made for this study were made along the lines suggested by Lofland:

'It is probably not necessary that one transcribe every word, exclamation or pause that occurs in an interview. Indeed, there may be entire answers, descriptions, and the like given by the interviewee that one will feel need only be summarised or recorded in the write up as having occurred. The point here is that one wants a written record of what the interviewee said so one can find it again, but one does not necessarily need a verbatim transcript of everything'.

In this way the written record indicates what is on the tape, if a transcript of certain sections are required, they can be made later.

The transcripts were studied in order that the major themes of the data could be determined. As the interviews progressed the researcher became aware of some of these predominant categories; but nevertheless a detailed study of all the data at the end of the field work was essential. At this point, the theoretical notes were transferred onto index cards, along with the student code, which allowed cross reference with the relevant tape. New theoretical notes were also made as and when this further study of the transcripts dictated. As the researcher became more familiar with the data, links between categories and potential categories became apparent. In formulating these links the strategy of 'packaging' was used. During the process of analysis an original set of about thirty conceptual themes were combined and integrated by means of comparing pieces of data and 'shuffling' the index cards until the final categories were identified.

Lofland (1971:127) has some very useful, and practical, suggestions in his discussion of 'Analysing Social Settings'; his work was drawn on heavily for both analytic and 'spiritual' guidance. Perhaps his most insightful writings are concerned with what he calls "little piles of paper and actually writing text". He puts great emphasis on preparation of material and thoughts before writing but then goes on to say:

'It seems, in fact, that one does not truly begin to think until one concretely attempts to render thought and analysis into successive sentences. All the elaborate preparation described above amounts mostly to a device that allows one's head to work in an orderly fashion when it comes right down to saying something on paper. For better or worse, when one actually writes he begins to get new ideas to see new connections, to remember material he had not remembered before'.

Lofland's point about ideas emerging as the writing takes place was true of this study. However much ordering of the theoretical notes, making of searches for extracts of data and sketching of arguments took place in order to start writing; it was only once the writing started that the real shape of the category took shape. It is also true to say that only at this stage was the category shown to stand or fall. In Lofland's words again:

'He may begin to find that a section just does not make sense. It will not write. Even more disturbingly, while actually writing he may find that the entire general design could and should or must be re-done, re-conceived or re-ordered'. (Lofland 1971:127)

It was often during the attempts to write up a category that the combination of several categories occurred. The connections could be seen more clearly and the merger of two or more major conceptual themes was the result. A final word from Lofland (1971:129) concerns the balance between analysis and description; a crucial one in qualitative work. He describes it in terms of analytic and descriptive excesses and where there is:

'Description and analysis together without one crushing the other (they) constitute enlightening and balanced sociological work'.

Note: Throughout the extracts from the transcripts
(...) = edited by researcher
... = natural discontinuity in speech

When this balance exists Lofland refers to the result as analytic description. The researcher has aimed for such a balance in the present work, the reader, however, will need to be the judge of that.

This is as far as a description of the analysis can usefully go for the nature of the work makes a detailed description of the mode of analysis redundant without the attendant data and interpretation. To return to Rock's (1979) discussion of social forms, it is necessary to have both the form and the content if either are to be of use in describing a phenomenon. Simmel's comparison of grammar and utterance with form and content is useful here. A description of the analytic procedure is of little avail without inclusion of data, as indeed would be a discussion of the data without recourse to analytic procedures.

'No form would appear without content, and content could not become manifest without form. It is neither possible to examine pure form which lacks all content, nor pure content which lacks all form' (Rock 1979:41).

Insofar as the researcher can know, the interpretation presented represents a plausible explanation of the data and the students' world. This kind of study stands or falls upon the credibility of the story it tells and interpretation it makes for the reader.

Strong (1979:250) has an insightful footnote in his methodological appendix which seems to be an apposite close to this chapter:

'Some authors have been so disturbed by the failure to generate foolproof interpretive methods that they have abandoned all interest in conventional subject matters and concentrated solely on analysing the methods that are used in everyday life to this end; their hope being that here at least some certainty is to be found ... The best we can hope for in this world, even if we study practical reasoning, is a plausible story'.

CHAPTER 5

'Learning and working'

The category 'learning and working', started out as a convenient handle to the data concerned with the student nurses' accounts of their experiences in the hospital wards. It seemed that, although the students possessed the student title, in practice they were often functioning as members of the work-force. The development of the category involved several issues which are addressed below, in an attempt to explain, from the students' perspective, the position in which the student nurse finds herself; namely, that of student 'doing nursing' work.

The students saw the college as the source of the theoretical (1) input to their training and the demonstrator of the correct way to carry out practical nursing. On the wards, however, they found that not only were college techniques not used, but that nursing auxiliaries often had as much, if not more, responsibility as the students for the basic care of patients. These data led to a discussion, in subsequent interviews, of the place of 'theory' in nursing and a questioning of whether it was, in fact, necessary. That is to say, if the students and auxiliaries functioned in a similar way, what was the justification for the theoretical component of nursing education. The competence of the student as a worker, capable of undertaking the necessary tasks to complete the nursing care routines, is examined in the context of her supposed student role; thus, the service versus education division is explored. This discussion has implications for the needs of student nurses throughout their training in terms of support and guidance.

(1) 'Theoretical' is used here in the way that the students used the term; that is to describe the content of their college lectures.

College versus ward

One of the most striking features of the students' account of their nursing world was the difference between nursing as taught in the college and nursing as it was experienced on the wards. This fact of student nurse life is not an exceptionally new one. Indeed, it is almost a part of nursing folklore that these differences exist. Olesen and Whittaker (1968:143) found that the student nurses in their study experienced the same phenomena:

'Perhaps the most exquisite dilemma of all with respect to faculty-staff (i.e. college-ward) relationships lay in instruction. It was incumbent on faculty to indicate what they thought were the best ways of doing things, ways that sometimes ran counter to what students saw staff doing on the wards'.

What is interesting is the fact that, whilst the differences are quite profound, the students accepted them quite readily. It was generally held that the college should teach the "correct" way but that in the real world there was not time for this and so the "correct" way was adapted on the wards to suit the prevailing situation. At the operational level, this ward/college difference is a clear cut fact of the student nurses' life. However, there are a number of inter-related issues involved when the question is examined more closely. These issues are explored below and some tentative conclusions drawn.

Student nurses are taken into the health service on what is essentially an apprenticeship basis. Their time is divided between lectures and demonstrations in the college of nursing and practical nursing experience on the wards, in a variety of specialties. The students form a large part of the work-force on hospital wards. Although they always work under supervision, as they are not legally qualified to practise independently, the degree of supervision varies

enormously, at one end of the continuum 'nominal' would describe it most appropriately. One of the major difficulties facing these student nurses, it seemed, was the balancing of the roles of worker and learner. The dichotomy is becoming ever more apparent as the colleges of nursing move in the direction, albeit slowly, of other institutions of higher education. That is to say, the student nurse is being encouraged to develop the student side of her role, and this throws the worker element into greater relief. The students naturally learn much of their practical nursing skills in the hospital wards. Thus they have to determine how to select the 'good' from the 'bad' influences which they encounter. After they have determined this, they must develop a style of work, with both the qualified staff and auxiliaries, which will allow them to function in the wards in such a way as to facilitate their learning. This facilitation is achieved in part by the way they relate to the permanent staff but largely by their willingness and ability to be a member of the work-force on the ward.

The student nurses are aware of the differences between the college ways of 'doing nursing' and those of the permanent staff of the wards. Since the student nurse spends much of her time on the wards it is at one level a matter of simple expediency which leads her to perfect ways of discovering and complying with the 'ward ways' of nursing.

K.M.: How much do you think what you are taught in the college affects how you nurse, rather than what you see people do in the wards?

Student: I think it is, you know, you get taught in school the proper way for everything but you've never got time to do the proper way in the wards. I think you should, you know, I mean, you don't really have that much time in school; so I mean the theory is good (...) you need it,

what you get but like the nursing they just sort of teach you the basics in the school and the proper way to do it so that when you go into the wards, I mean, you've got, well, you know what should be done, what's going on, so that you're not really totally ignorant about what's getting done (...) (1)

This student had no difficulty in both seeing and accepting the fact that the style of nursing taught in college did not resemble exactly that found on the wards. Although she recognises that the college teaches the 'proper' way of nursing her later comment about knowing "what's going on" when she is on the ward indicates a more important function of the college. This has to do with introducing the students to sufficient theory to allow them to function as part of the ward staff. Clearly, if a student nurse was entirely unaware of the possible range of events which might surround different categories of patients, she would not make a useful member of the ward staff. Thus, although there is not deemed to be time on the ward for the nurses to carry out procedures in the 'college way', the college teaching seems to furnish the background information which enables the students to function on the wards.

Another student said that she preferred an orderly ward where things were done 'properly' which led to a discussion of where she learned to nurse 'properly'.

K.M.: ... and you find the way the sister organises the work affects the way you actually nurse?

Student: Yes, because if you've got somebody who is really slightly slapdash - the permanent members of staff tend to be like that you know. They say 'don't bother doing it like that' (in the case of some dressings being done in the bathroom); it's not sterile at all and you feel well this isn't really right but when somebody says 'we haven't really time to do that just stick a bit of gauze on', and that's it. I feel that if the sister were here (...).

K.M.: How does that affect you and your development as a nurse?

Student: Well it worries me from time to time because I like it when I go to a ward where things are done properly, you know, things are done the right way. And I think at the same time it also makes you awfully - well you change - you go to another ward and do things as you have been doing them in the other place (...).

K.M.: When you relate back to the proper way of doing it, where do you pick that up from - do you know?

Student: From the school, I think. That's what I found when I first came out of school - was the way things were done we were taught how to do it properly - its not all that different from what we saw happening in the ward.

K.M.: And how do you come to terms with that?

Student: Well, I think in school you are taught the correct way of doing it but you have to make slight modifications when working in the ward or you can still manage to do things properly. (5)

This student started out by giving an example of how things were not always done 'properly' on the ward. By the end of the exchange she was saying that the differences were really mere modifications of the 'proper way'. She did not attribute any blame to the trained staff who were doing the 'sterile' dressing in the bathroom but thought that if the ward sister were present things would be done 'properly'.

The students appeared to sanction the 'ward way' of doing things because it was efficient and worked, even though it was not entirely correct. There are studies in the area of industrial sociology which illustrate similar behaviour in organisations. There are, on the one hand, hard and fast rules which must be seen to be obeyed and not dismissed as impractical; and on the other, these same rules are frequently broken. The breaking of the rules is a necessary part of the smooth functioning of the organisation; new members must be socialised in this legitimated breaking of the rules. Bensman and Gerver (1963) describe the breaking of one rule in an airplane factory

in the United States. The use of the 'tap' is a means of achieving alignments in assembling aircraft wings, where during the production process the correct alignment between nuts and plate openings have become distorted. Use of the 'tap' is both dangerous, and forbidden, yet it is frequently used with the unofficial sanction of the foremen. Bensman and Gerver argue that analysis of deviancy within an organisation using a functionalist view is not helpful. This, they say, is because it assumes a total approach; all parts of the organisation working towards the same ends. In such an analytic approach deviation from the rules implies a rejection of the norms of the system; the authors suggest a different analytic approach, which says people not systems have ends and these are accommodated in collective behaviour. They found that from the viewpoint of production the use of the 'tap' is imperative to the functioning of the production organisation, even though it is one of the most serious work crimes. This is recognised even at official levels, although only in indirect ways.

The students in the present study described behaviour which they knew to be incorrect yet would justify in the name of accomplishing the task in hand. The student's comment about such behaviour not happening when the ward sister was there illustrates the fact that some notion of right and wrong was operating. One could speculate that the sisters knew very well what was going on, but, unofficially, chose to ignore it.

Similar deviant, yet accepted and organisationally necessary, behaviour was described by Ditton (1977) in the case of bread salesmen. This involved 'fiddling the customer' and Ditton explains how new

workers were socialised into this behaviour:

'institutionalised socialising arrangements are deliberately constructed by the bakery management to teach recruits to regularly and invisibly rob customers on behalf of the company'.

Whilst it is not being suggested that similar criminal behaviour goes on in hospital, the analogy with the industrial scene is an interesting one. It seems that the acceptance of an 'official' set of rules alongside organisationally acceptable deviance is not peculiar to nursing. This acceptance is evidenced in the comments of another student who thought that the nursing practised on the wards was not too different from school:

'the big difference is that the corners are cut, in school you do the whole thing, on the wards sometimes you don't have the time'. (11)

The overriding impression given by the students in their discussion of the differences between the wards and the college was that of a matter of fact approach to the divide. It seemed that the student nurses, although they came to study nursing at the college of nursing were not in the least perturbed by the discrepancies they encountered in the wards to which the college attached them.

The Clinical Teacher

The differences between the wards and the college of nursing can be perhaps best highlighted in the consideration of the function of the clinical teacher. The clinical teacher is a member of the staff of the college but is responsible for the practical side of the teaching and thus most of her work with students happens on the wards.

K.M.: Is there much relationship between what is taught in the college and what you see on the wards?

Student: No, you have not got time to do what they tell you. Some of the things, like say in some wards they go just about right by the book, but in other wards its just a case of do what you can by the book. Carry on as best you can. It is just using your commonsense.

K.M.: I just wondered; you hear people talking about running the ward as if it is something different from anything else that goes on (we have discussed it in earlier interviews), be it teaching students or nursing patients, it is as if the ward has to run.

Student: I think a lot of teachers in the school should go back into the wards for a while, because, I mean, you get teachers telling you things and you go into the wards and you just cannot relate anything to what they have said at all (...). They do go around the wards but I do not think they are there long enough to see what actually goes on; and then everybody is on their best behaviour.

The student went on to say how working with a clinical teacher on the wards was not similar to the way ward work was usually carried out:

Student: (...) in the school you would be there for hours if you were doing a bed bath, I mean, say if you are on the surgical ward and you have got 25 patients you cannot take an hour on each patient or you would be there for the rest of your life.

K.M.: And when your tutors and clinical teachers come into the ward do they actually work with you? Obviously they do not do everything at the speed you would do without them; do they just take you and one patient and pretend it is like it was in the school?

Student: Huh, huh, that is exactly how they do it. It is just one patient and everybody else is wiped off the map. (24)

It seems that the ward/college divide does not exist on all wards to the same extent. The relationship between the clinical teacher and the ward staff varies, in some cases the ward sisters and the clinical teacher strike up a good working relationship and so the resultant experience can be a realistic one for the student. On the other hand, as the last students' comments demonstrate, the clinical teacher can be

seen as the college brought to the ward and whenever she chooses to work with a student for a few hours the student is deemed to be pair of hands lost to the ward. Although the reality is that the clinical teacher represents an extra pair of hands; the fact that she wishes to nurse according to the ways of the college rather than the faster adapted ward ways negates her contribution to the work-force.

The clinical teachers were seen to belong to the college of nursing, yet did at times further the service ends of the ward rather than the educational needs of students. Clinical teachers were also seen by some students to be closer in touch with the reality of the ward situation than were their colleagues in the college; they could help the students to adapt their college training to the ward requirements. One student gave a rather extreme example of this when she described her experiences as a first year student on a gynaecological ward. She had been told in the college that junior students would not be required to collect major surgical cases from theatre; they might conceivably be required to bring patients back after minor operations. The clinical teacher had shown her what to do in both circumstances "just in case". This precautionary measure was taken by the clinical teacher because the ward had no allocation of senior students; thus the chances of a first year having to undertake senior students' duties were high. The clinical teacher anticipated service needs and allowed these to subordinate the students' educational needs by introducing, out of context, the necessary knowledge for the care and transport of major surgical patients. This 'crash course' approach was dictated by the needs of the ward not those of the student.

A similar experience was sometimes described in relation to night duty. One student described her experience as a junior night nurse when "you are not supposed to be in charge as a junior on nights, but I was because we were short staffed". She enjoyed this experience and said that she gained confidence through it. It was the return to day duty which presented problems; when she said "everything is taken away from you, back to being just a wee student who doesn't really know very much". In this case the extra responsibility was seen by the student to be a positive learning experience; yet, in service terms, it was clearly just an expedient measure. The withdrawal of responsibility once experienced, was frustrating for the student. In some ways this oscillation of status depending upon the prevailing circumstances is one of the underlying difficulties for the student throughout her training. It is a theme which is picked up again below in the discussion of student and nursing auxiliary relations.

Students and Auxiliaries

In the light of this brief consideration of the student nurse's position, it seems that the student nurse is trying to do two things during her three years of training. The first is the *raison d'être* of her presence in the health service, namely to gain registration. The second is to function efficiently as a member of the main work-force of nursing. These two aspects of the student nurses' activity are never mutually exclusive by virtue of the fact that in order to obtain registration the student must put in a given number of hours practical nursing in a series of prescribed areas. This practical experience

must be accomplished satisfactorily, according to the standards of the ward staff. In order to meet these standards, it seems that the students must display an ability to function as one of the work-force of the ward. However, there remains the important question of emphasis; whether service or educational needs are given priority.

The students spoke a great deal about the amount of responsibility which they had on the wards; this was often discussed in relation to the work that the nursing auxiliaries did and the student's position, in terms of authority, vis-a-vis the auxiliaries.

There were mixed feelings among the students towards the auxiliaries largely because of the tension which exists between their reliance on the auxiliary for help in getting to know the ward routines and their insistence upon some differentiation between auxiliary work and nursing work.

Students sometimes felt that as junior nurses they had often been passed over for a nursing auxiliary if there was a job to be done which the sister or staff nurse knew that the auxiliary would be able to do more quickly. It takes more time to explain and show something to a student than it does to ask another, already competent, person to do the job. Nevertheless, the students saw the value of the auxiliaries and were quick to defend them if they felt the researcher was being in any way critical of them. On one such occasion the researcher had suggested that the students had some basis, other than experience, upon which to make their decisions and so, even though on the face of it the auxiliary nurse appeared to be more competent, the student did have a more legitimate stance from which to proceed, namely the 'theoretical' component of their training. The student

responded by saying that "lots of auxiliary nurses were very good" and that a lot depended upon the personality of both the nurse and auxiliary. The researcher pursued the issue about nurses working from a different starting point from the auxiliaries, who worked from past experience, which, it must be remembered, was sometimes considerable. This met with a firm defence of auxiliary nurses.

One student's comment exemplifies the students' feeling that the ward sisters tended to go to the auxiliaries before students when they wanted work done.

K.M.: Do you ever find that auxiliaries are doing things that the students should be doing, because they have this relationship with the sister?

Student: Yes, it's not supposed to happen, as far as the No 7's (Nursing Officers) are concerned it doesn't happen; but it does, a lot. They take the upper hand, especially with the junior nurses.

K.M.: Is that hospital-wide, or particular wards?

Student: Particular wards, I think, on the surgical side they tend more, the auxiliaries do their own work; bed baths, things like that. They tend to do their own work, water jugs and things like this. Medical side they tend to do the nurses' work, things students could be doing.

K.M.: What sort of things on the medical ward?

Student: Things like, they'll tell the student what they should do with this patient; you know like 'this is how we get them up' - like one the other day, patient had to get a bandage and re-bandage his feet; she just took it off and bandaged it up. (10)

Another student, when talking about geriatric nursing, said that there was no difference in the work of students and the auxiliaries; even in the areas of care where some technical nursing knowledge is required.

Student: (...) I think there is nothing wrong with auxiliaries apart from the fact that when something technical does come along they think that because they have been there for years they have the expertise and start telling you what to do 'you shouldn't be doing that like that nurse' - that sort of thing. It gets you quite annoyed because you think, I know you've been here for years but you haven't done any theoretical side of it and you don't really know what you are doing, just because you've seen other people doing it.

K.M.: So really I think that's what I was getting at; I'm not actually suggesting that we should do away with nurse training. But you are there as the work-force but quite often you are not allowed to put your thinking into practice, because you have got to do whatever is done there. It seems to be what people are saying, what would you say about that?

Student: I would agree with that. Most places have got a set routine, I suppose they have to but you've got to stick to it and if you have any ideas you get 'we don't do that here dearie, get on with it'. (37)

The observations of the first student are of interest because they serve to highlight the areas of nursing which she was prepared to recognise and defend as 'nursing'. She resented the interference from the auxiliary nurse in overt technical tasks such as dressings and bandaging; while she was not prepared to distinguish between her own basic care of a patient and that offered by an auxiliary. This view she maintained even when the researcher pointed out, at some length, that the auxiliary can only, for example, look after stroke patients so long as each patient behaves in much the same way as the last. That is to say the auxiliary can only work from past experience. Whereas the nurse has a background of 'theory', which naturally benefits from experience, but she can thus plan care and anticipate reactions without a previous personal experience of the situation. The commonsense knowledge which the auxiliaries exhibit should not be underestimated. The researcher's comments, made in order to see what

the student would say about the difference between her and the auxiliaries, were perhaps a little too polarised. The auxiliary as a functioning front line worker cannot be considered to be devoid of a store of experiences which she has assimilated into some working knowledge, at a commonsense level. However, the second student (above) recognised the distinction between knowledge and experience as a basis for action.

As it has been suggested above, the students see the auxiliary as a major figure during their time on the wards. The students often identified the auxiliary nurse as the person who teaches them what to do when they go to a new ward. The auxiliary is often a long standing member of the permanent ward staff and as such knows a great deal about how the ward works and how sister likes things to be done (cf. Hardie 1978). This theme is developed in Chapter 9. Suffice to say here that the nursing auxiliary is, for the student, an important force to be reckoned with. When the student first arrives on a ward she needs the auxiliary, for it is the latter who, more often than not, initiates her. When the student eventually finds her feet she seems to have difficulty in shaking off her previous dependence upon the auxiliary who seems to remain an important figure and not one to be critical of or to feel superior to. The logical conclusion to this kind of argument is that in practice there is, in some areas, very little difference between the work of the student nurse and that of the auxiliary. On the surgical wards there is possibly more of a distinction because of the amount of technical nursing to be done.

The work of the auxiliary, as portrayed by the students, is of some importance; particularly when the auxiliary is a long standing member of the ward team. The auxiliary is in a potentially powerful position, even though she is at the bottom of the hierarchy. The students said that they relied on auxiliaries for guidance in their early days and saw that the ward sisters made free use of them. Mechanic's (1968:416) discussion of the power sources of the 'lower participants' in complex organisations is relevant here:

'It is not unusual for lower participants in complex organisations to assume and wield power and influence not associated with their formally defined positions within these organisations'.

Mechanic argues that these workers have personal power and no authority. There is a distinction to be made, he says, between formal and informal power. The formal power holders in an organisation are those near the top of the hierarchy, by virtue of their formally structured access to information and personnel. Yet, Mechanic says:

'lower participants in organisations are frequently successful in manipulating the formal structure because they may have informally attained control over access to information, persons and instrumentalities'. (Mechanic 1968:418)

This type of informal power, Mechanic suggests, is often gained where there are "numbers of well entrenched lower-ranking employees, and at the same time high rates of turnover among higher-ranking persons in the organisation". This, of course, sums up the position of auxiliaries and student nurses in the hospital wards.

'Practice' versus 'Theory'

This line of discussion led to an exploration of the place of theory in nursing. 'Theory' is the term which the students used to describe the lectures which they had in the college, in other words the book-work, as opposed to their practical work. Thus, 'theory' does not have anything to do with 'theories of nursing' - it is simply the term used in contradistinction to 'practice'. If nursing auxiliaries, who receive little or no formal training, can do most of the nursing which takes place, why have a large theoretical input in the general nurse training?

During discussion with one student the question of practical versus theoretical nursing arose. Whilst most of the students would, with varying degrees of conviction, defend the need for 'theory' in nurse training this student thought it was not all that important.

K.M.: What I am really interested in is what you think is important about nursing, and if it helps to start with thinking about patient care.

Student: The comfort of the patient is really important as well ...

K.M.: How do you ...

Student: Your attitude towards the patient physically and mentally, you know, telling the patient; how gentle you are with the patient. The practical side of nursing I think is more important than the theoretical side at the moment, as a student nurse, the responsibilities you are given as a student nurse makes it more important to be more practical than theoretical, I think.

K.M.: (...) What would you call theoretical, do you see it as two separate sides of the ...

Student: It's not always two separate sides, eventually things throughout your training do click together better; but as far as practical nursing, when you're with the patients on the ward just doing your basic nursing care without thinking what's actually wrong with the patient, as with

the 'Nursing Process', you work from the 'nursing care plan' without really knowing the diagnosis or what's wrong with the patient. (35)

Another student defended the place of theory for its intrinsic interest value.

K.M.: Do you find that you learn more on the wards or in the college, or is it different things that you learn?

Student: You learn more on the wards but you learn while you're doing them. (...) you sort of say this is done for such and such a reason; but in college you've got it down on paper, you've got it in your books - exactly why it's done. The practical you learn on the ward, but it's best to know the theory behind it.

K.M.: Yes, because some of the conversations I've had it almost seems that there are two things going on - you are learning all the things that you need to write down to pass the exam on the one hand and then things are so different, in some ways, on the ward and other things you don't really have to know so long as you do the work.

Student: I like to know why I'm doing things. I'm curious - at school I found subjects that I had to understand easier than the ones you just learnt off a page because I like to know why I do things. That's what I've found on this block actually, (the student was in the college for a 'study block' at the time of interview) quite difficult because you had doctors' lectures and the exams weren't on the doctors' lectures; your exams were on the nursing care, and I was getting so caught up in all the little blood cells moving around (reference to haematology lecture). Then I was thinking but I don't need to know that, but I mean it was nice to know that in the background. I found myself sort of caught up in all the details.

K.M.: Is there a tendency to feel that the learning theory side of it is condition, signs, symptoms and biology or what have you; and really the nursing does not figure very largely, or does it, in what you feel you have to learn?

Student: I don't really think it figures very large at all. I mean it's nice to know but when you are actually nursing in the ward (...) because you are doing the procedure you're not really thinking I am doing this because of such and such a reason (...) (30)

When the students discussed theory, as opposed to practical nursing, they were not always referring to the same phenomenon. The student quoted above clearly linked 'theory' with medically oriented studies such as diagnosis. Theory and disease conditions were often compared and juxtaposed with basic nursing care, viz:

'When you first start all you do is basic nursing care, after that it is lost, all you do in other Blocks is diseases; basic nursing care doesn't come back into it'. (39)

There was also often an implied hierarchy in the terminology, "just basic nursing care" compared with "lumbar punctures and sterno-marrows as demonstrated and explained by the doctors". This is one of the many examples in the study of the dominance of the medical profession. The students appeared to be attracted by the lead taken by what Freidson (1970) has called the 'dominant profession' in health care. Knowledge which is linked with medicine appears to be prestigious knowledge and therefore it is legitimate to draw upon it in order to bolster the status of nursing. Knowledge about "just basic nursing" was not, it seems, regarded by the students in the same light. The question of what might be considered to be legitimate and illegitimate knowledge, upon which to base nursing status, is addressed in relation to professionalism in Chapter 10.

The data presented above are examples of the mixed feelings of the students towards the role of 'theory' in nursing. One question which the data posed was: why have a large theoretical component in the general nurse training?

It seemed from the way in which the students used the word theory that it did have a variety of meanings. Sometimes it meant the knowledge base upon which to found an activity, more commonly it was

simply used to distinguish the parts of nursing which are taught in the college rather than those learnt on the wards. However, as we have already seen, theory was generally taken to mean medically oriented facts based on diseases and their signs and symptoms. There was an overall impression that the students saw nurse training in terms of a series of medically oriented lectures in the college, basic nursing picked up on the first wards and some follow-up demonstrations of medical techniques, supplied presumably so that the student nurse becomes competent in assisting at these procedures. The professional dominance of medicine is reflected even in the nursing education programme.

Clearly it is too simple an approach to reduce all of nursing to a few categories, distinguishing between technical and basic care, with a view to specifying which of these tasks must be undertaken by trained, or at least learner nurses. The socio-psychological factors and the 'how is it carried out' aspects of nursing care are considered by many to be all-important. However, the fact remains that, according to the evidence of the students in this study, much of the nursing experience which they had was carried out in settings where they could be seen to be interchangeable with the auxiliaries. Some of the students in the study discussed this interchangeability in terms of what it meant for professional nursing. One student said that auxiliaries were doing more nursing work than they used to, "they are coming into student territory - doing more and more things". She gave as an example auxiliary nurses taking patients' temperatures and pulses, and queried whether the auxiliary would note the quality as well

as the rate of the pulse. "We are taught to look for abnormalities and consequences, e.g. fibrillation - suppose then the charts were done by an auxiliary".

These tasks are being sloughed off to the auxiliaries in much the same way that they were once passed from the doctor to the nurse. They have become low-prestige and routine tasks which nurses are seeing fit to hand over to the auxiliaries, who are only trained in an ad hoc way to do whatever is required of them. As one student put it "given a good training by a ward sister they (auxiliaries) are good and valuable". Hughes (1971:307) describing how, in striving for professional status, nurses are handing on their work to 'aides and maids'. In this professionalising effort, paradoxically, the nurses are taking over cast-off medical work. This taking on and casting off should be undertaken with caution, as Johnson (1978) warns by quoting Augustus De Morgan (1872:377) who said:

'Great fleas have little fleas upon their backs to bite 'em
And little fleas have lesser fleas, and so ad infinitum'.

Why theory?

If one is going to argue that theory is an important part of nurse training and, that it is important for patient care, a case has to be made for the utility of theory in terms of patient welfare rather than in terms of successful professionalising on the part of nurses. The question of interchangeability of students and auxiliary nurses could well damage the case for the former. In the case of the latter it could be suggested that the introduction of theory into what might otherwise be an essentially boring job serves to maintain the morale of the nurses and attract intelligent people into the work.

The case for the utility of theory in nursing practice is addressed first. If it is to be argued that all nurses need some training, currently a three-year programme, then there must be some economic, if not any other argument for maintaining this policy. It must be the case that nursing care has to be carried out by trained personnel if a cogent argument is to be put forward for training the current numbers of nurses. Clearly, nursing care is not always undertaken by qualified staff; the majority of the nursing work-force comprises unqualified and untrained personnel, namely students and nursing auxiliaries respectively. Nursing auxiliaries and learner nurses are at present working under the supervision of a small number of trained staff. The whole system is dependent upon a constant stream of students presenting themselves for training each year. The process continues in this way because qualified nurses are constantly leaving the work-force. The newly qualified staff nurses form a highly mobile population in that they move from post to post. There is also movement in and out of nursing; the most common reason being marriage and family. Employment of nurses has to be looked at, it must be remembered, in the wider context of the labour market and in the light of the changing role of women in society (Mercer 1979). Thus, the system continues to provide a large work-force of students and to lose a substantial number of trained staff, albeit temporarily.

What of the interchangeability of students and auxiliaries? One student described the operation of the student allocation policy on different wards. On the wards where there was a large number of students allocated there were consequently few auxiliaries. Moreover, in such a situation the auxiliaries only help the nurses, "they are

really only nursing aides". The students form a mobile work-force which can be shunted around the hospital as and where required. The auxiliaries can be seen as gap-fillers where there are not enough students allocated; a fact which exemplifies the interchangeability of students and auxiliaries. The researcher put this type of argument to one student.

Student: The NHS couldn't survive without auxiliaries, the publicity recently about not calling them nurses etc. - I don't think is justified. I learnt basic nursing care as an auxiliary. (Student spent few months prior to training in auxiliary work)

K.M.: You could argue that an auxiliary can do anything if shown.

Student: They don't realise the implications you should know - why you do what you do, that's where nurse comes into her own.

K.M.: Do you see that in practice or does she do no better than the auxiliary because when she gets into the ward she follows the routine instead of putting what she learnt into practice?

Student: I think you can see it in practice. Though you see a lot of bad practice in students and trained nurses (implication being not just bad practice from auxiliaries). You see a lot of students who don't function well.

K.M.: If you put a set of students in to function routinely.

Student: I actually find in some wards that the auxiliary will teach the basic nursing care. That's OK, with in-service training; they are taught more or less what we are taught in block. I don't know that it affects me that nurses are getting more responsibility but what could annoy me would be if I thought they were not doing it properly. I feel that auxiliaries are being given lists of their duties on more wards now because nurses feel that their territory is being encroached upon. (31)

The above discussion is presented in order to demonstrate firstly how the student nurse defended the auxiliaries' position especially when the researcher was seemingly attacking the auxiliary nurses' competence. It does seem, according to the students, that for the most part an

auxiliary, with limited but focused training, could undertake much of the routine basic care, under suitable supervision.

The arguments for a theoretically oriented nursing training seem to be aimed at the professionalisation of nursing rather than the improvement of patient care. The questions of profession and professionalising are addressed in Chapter 10; mention is made here in order to set the worker/learner divide into some context for discussion.

Student or Worker?

The researcher was interested in how the students saw their role on the wards, that is in terms of being a worker or a learner. This issue produced some interesting discussion which relates, in part, to the whole question of profession vis-a-vis nursing. The main point being that if student nurses can move from ward to ward in fairly rapid succession, find their way into an established routine and then proceed to care for patients in the manner prescribed by their seniors with or without much more knowledge of the patient than the nursing auxiliaries have, can the end product of this training be a professional.

The distinction drawn from the data between student nurse as learner and student nurse as worker has some close connections with the differences between the wards and the college of nursing. It has been singled out for separate discussion because it does have some subtly different consequences. One student comment, which was very much to the point, sums the category up neatly thus: "you just forget what you were taught in school and go ahead and work for the ward". One student thought that even the qualified staff should do the 'basic

tasks' because "that's nursing, at least what I see nursing as".

This led to a discussion of how she got along with the permanent staff.

Student: SEN's I get on really well with because they are in with the patients. Staff nurses I don't know; some of them I get on really well with but not on a working basis. They are giving you the orders, you run to them for help and that's it. (...) When you first go on the ward they are really helpful but if you don't progress as quickly as they think you should they can turn round and be really nasty.

K.M.: Progress in what way?

Student: Well if you go on say your first ward and they think after, say, three weeks you should know how to do things like bed bathing, observations and things like that, simple things, and if you are still incompetent in that then they can turn on you. (27)

The student had been talking about the different ways of doing things on the different hospital wards. The emphasis seemed to be upon learning how the ward staff, or more properly, the ward sister liked things to be done. The researcher raised the student/worker divide issue:

K.M.: (...) Do you see yourself as a student who has come here for an education or do you see yourself as a worker?

Student: A worker. You see, well both at the same time but for instance; when you are in block you definitely see yourself as a student and this is a good opportunity for you to learn and when you are on the ward you are not only trying out what you've learnt but you're taking in how that actually works, in a day to day basis. Also if you were just regarded as somebody there to learn, you picture a student nurse just standing there watching everything; whereas obviously that is no good because you are part of the work team and especially in a medical ward you are there to pull your weight, just the same as the auxiliary or anybody, and if you don't they'll let you know about it. In that respect when you are on the wards I think, sometimes you think, what is this, cheap labour, this is ridiculous, especially on some medical wards, on the other hand there is no reason why you shouldn't be doing it. But you don't feel

that you are being filled full of vitally important knowledge, the fact that you have been emptying bedpans for the past two hours and that Mrs X needs her bed changed again. It's both of them at the same time, but when you are on the ward you are a worker first but you are learning the work as you go along. It's hard to describe. I know what you mean (...) I don't see myself as being a student like a student, like a student at university; I see myself as being trained but you're working as you're being trained, it's an apprenticeship type thing. For that reason I think we are entitled to just as good a salary as anybody else that's pulling their weight and working hard, on the other hand you have to keep up your book work etc. (29)

This student's comments are quoted at length in order to illustrate the discussion of apprenticeship and nursing.

The students can be seen to be in a position which is, in some respects, similar to that of an apprentice. One student actually differentiated between her status and that of a university, or 'real' student; and in doing so she employed the label apprentice. Yet the terms of the student nurse's apprenticeship are somewhat different from those of the traditional apprentices to craftsmen. The students move around frequently and cannot be said to be apprenticed to 'masters', firstly, because of this mobility and, secondly, because it seems that much of their time is spent working with auxiliaries. The medical students in the study by Becker et al (1961:194) were seen to develop apprentice roles during their second year:

'The student does clinical rather than academic work. That is he gets his training primarily by working with patients rather than through lecturers and laboratory work ... Though he remains in many senses a student, he becomes much more of an apprentice, imitating full-fledged practitioners at their work and learning what he will need to know to become one of them by practising it under their supervision'.

The medical students were working with qualified doctors during this apprenticeship. In the case of student nurses their 'craftsmen' should be the qualified staff with whom they work; yet it is, according to the students, much less frequently that they work with trained staff than they do with other students and auxiliaries.

The quasi-apprenticeship nature of nurse training is shown in an interesting light when it is considered that much of the on the job learning happens between learners, senior apprentices teaching junior apprentices, as it were. This teaching sub-culture is not altogether a surprising factor when considered alongside the comments which students made about their ability to function efficiently as workers. If the trained staff expect the student to pick up the 'job' in a short space of time and fill the vacant slot on the ward; whenever the student needs to know how to do something in order to function efficiently, she is more likely to seek help from a fellow-apprentice than a trained member of staff. This reliance on other students rather than the 'craftsman' serves to point up the contradictions in the simple notion of a student apprenticeship.

Student nurses felt that the trained staff expected them to become efficient workers in quite a short space of time. This staff expectation can be seen as a consequence of the student nurse being viewed as a worker. It also demonstrates the kind of consequence of the worker/learner divide which go beyond the ward/college differences. This expectation is of interest on two counts, firstly, the student nurses are, by definition, learners and as such should not be expected to slip into full work roles immediately. Secondly, the very fact that the students move from ward to ward militates against their

becoming efficient workers in a short space of time because each time they achieve that state they are moved on.

The trained staff are the nurses on whom the learners might model their behaviour. The students complained, however, that they did not often get the chance to work with qualified staff. Ward sisters sometimes spent their time in the office and so students got few opportunities to see a ward sister working with patients. This was not always the case; one student said "you are very impressionable on your first ward, watch the sisters, these are the people you model yourself on". Most of the students could remember one nurse, often a senior student, whose behaviour had impressed them. "In the first and second year you model yourself on others if I was impressed by them, I acted like them - not so much now". This student said that you could pick up a lot of different ways of doing things and so she opted for the "tutors way". This presumably represented some constant force in the training.

One further aspect of the position which the student nurse finds herself in has to do with the support which she receives during her training. Consider this student's comments:

K.M.: How do you get to know how you are getting on? Is there much feedback? I know you get an assessment on each ward, but on a day to day basis can you feel if you are any use to them? (Referring back to student's comment about being useful)

Student: You know yourself if you have been in the way or are being helpful - the way they act towards you (...)

K.M.: Do you get any positive feedback if you are doing well or is it just

Student: No - just if you're not doing well. Prefer a weekly assessment, not necessarily written but just to say 'you did well this week but do some more on your nursing care'. I think that a ward report is awful.

K.M.: It's a bit late anyway isn't it?

Student: Yes, if they told you at the time you could change, it's just left and written in a report later.

Later on in discussing the differences between ward and college the same student went on to say that some of the things which are acceptable on exam papers would be laughed at if mentioned on the ward. She didn't think that this could be pointed out to her tutor:

Student: I don't like it but that's the way they are (i.e. practical ward nursing and college teaching different), there is nothing you can do to change it; unless you go to Miss - (...) knock on her door and have it out with her, I'm sure she'd be very chuffed (with sarcasm).

K.M.: (Pointed out that the worker/student divide was one of the analytic concepts which she was exploring at the moment).

Student: It is, it's true. You don't like saying it to your tutors or they say 'a trouble maker her you know'. They say 'any problems you have just come down' like my personal tutor, I couldn't tell him anything.

K.M.: Do you feel you get much support if, suppose you make a mistake (...) you said you get told off when things are wrong; and not told when they are well, do you feel that you are not really supported?

Student: Well if you do wrong, they let everybody know about it. Clinical teacher gets informed, get told to come up, they never come to see you. The Nursing Officer gets told and it gets written down in your thing (record). (28)

The lack of support felt by the students was closely associated with their need for some feedback from the qualified staff. One of the strangest features of the 'apprenticeship' was the reward system. A student could often tell how she was progressing by the attitude of the trained staff. "If you are getting on OK the staff leave you alone - they don't really bother you". This, according to one student, could

sometimes be frightening as she had more responsibility than she felt ready for; she also felt that this gave the trained staff an "easy time". It seemed that the reward for being a good apprentice, and seeming to be coping and "getting on all right" was to be deprived of attention from the trained staff. Thus, the reward for good behaviour was no teaching. One student had difficulty in interpreting the reaction of the trained staff. When asked about feedback from the staff she said that she sensed her progress from what she was given to do. She saw it in terms of how far the trained staff trusted her, "if left to myself they know I'll do it". However, she did wonder if they were not "just cutting corners and giving it to me because they can't be bothered to do it". Her other explanation, in the light of the fact that another student from her set never got the same amount of 'senior work' to do was that "I don't know if I get it because they don't like me or because they trust me!" Such was the interpretation of the feedback received by this student. Her views, whilst not shared by all the students, serve to highlight the whole question of the rewards, feedback and insights involved in learning to nurse - 'on the job'.

Assessment and Counselling

The idea of the students' need for feedback and some idea of how she is performing led to a consideration of the question of support for student nurses during training. The college of nursing runs on personal tutor lines, that is to say each student has a tutor who is responsible for her welfare, academic and personal, throughout her period of training. It is interesting to note that there is no

separation of the academic from the personal aspects of the tutor's role. The common practice in higher education is to have an academic tutor and a personal tutor; in some attempt to separate academic assessment and progress from personal affairs. Several students said that they would not go to their personal tutor if they had a problem. This was sometimes simply a personality difference. One student talked about the difficulties she had experienced in talking to patients about their diagnosis. She said that there could be no help from the college in these matters, it was much better and realistic if it came from the ward staff. The researcher asked if the personal tutor could have been of any assistance "don't think the tutor is much help, I wouldn't go to mine - tries too hard to be nice". There was also a fairly general feeling among the students, typified in the above extract, that anything discussed with a personal tutor would be entered into the student's files and work in some way against them.

The tutor's dual role of assessor and counsellor does not appear to be an acceptable, or credible, one from the students' perspective. The students were suspicious that counselling sessions might degenerate into assessment activities resulting in negative information going into their files.

There were, however, very real problems facing the students and some coping mechanism is clearly needed. The two extracts below illustrate their difficulties:

'I've become very cynical about life, more depressed than I used to be - now I've seen what can go wrong in life ... I think everyone is dying, everyone has got cancer; I have to go home to see friends etc. who are not dying'. (38)

The researcher asked if she had any support over this in her training for instance did she feel she was allowed to be upset. "No - just be a nurse and smile". She did qualify the reply by saying it depended upon who she was working with and how they reacted. Also, talking to other students, both on the wards and in her own set, was of great help. Another student summed up the general need for support of students when she described her early days in nursing "first couple of days especially, it's sheer hell - the last thing you can think of is how to reassure someone else; you want to be reassured yourself".

The question of support for student nurses is raised again at various points in this analysis. In this context it seems that support is being offered in a formal way by the college of nursing yet the students feel that support is needed on the wards. It therefore becomes a matter of chance and luck, depending upon who the student is working with as to whether she gets the desired help or not. The learner/worker divide is relevant here; on the wards the student nurse is often regarded simply as a worker and so should be able to cope with her lot. The college of nursing sees the student as a learner and offers the personal tutor service accordingly. The student, balanced between these roles, often misses out on the support she needs.

Much of the problem, it is suggested here, lies in the blurring of assessment and tutorial responsibilities both on the wards and in the college. The students felt unable to express any doubts or difficulties, for which they might reasonably expect advice and tutorial help, in case they simply got recorded and counted against them. This

fear suggests that much more emphasis was laid, according to the students, upon assessment than on counselling and support.

Discussion

In this chapter the student nurse's dual status of student and worker has been examined. This divide is upheld structurally by the split which the students perceive between the college and the wards. The students were very ambivalent in their attitude towards this divide. There was a tendency to see both sides of the problem and in so doing they could neither reconcile the two nor come down in favour of one or the other. This is an important point as it reflects the ambiguities which exist in nursing; and which are clearly present in the students' nursing world. Perhaps the most striking part of the analysis is the apparent interchangeability of students and auxiliaries as part of the work-force. This last point led to a consideration of the need for a theoretical component of the student nurse's training. The major reasons put forward for the inclusion of theory were firstly to distinguish the student role from that of the auxiliary; and secondly, to provide an interest in some of the monotonous and less stimulating areas of the work.

The conception of student nursing as a quasi-apprenticeship was raised and is taken up again here. It is maintained that apprenticeship is not an entirely satisfactory term for the student nurse training system for the reasons already mentioned, namely lack of a 'master' and, student mobility. The former is the most fundamental reason. A craftsman who had an apprentice attached to him invariably linked his craft to some scientific knowledge in the daily carrying out of his task. He also had a pride in his craft of which he was indeed master.

The apprentice in such a situation was tutored in the relevant science, mathematics, geometry etc. (Braverman 1974).

The question of a need for theory in nursing in order to stimulate the student nurses in areas where the work is dull and repetitive is closely tied up with the idea of the interchangeability of students and auxiliaries in the work-force. Braverman's notion of 'degraded work' is pertinent here. His argument put briefly, and it is to be hoped without doing it much violence, states that as technology has advanced the labour processes have become at once sophisticated and tedious. Sophisticated because of the technology and detailed planning involved for one set of workers and tedious because the work can be broken down into small parts which require little or no skill to perform. Scientific managers undertake the creative part of the process, whilst workers at the operational levels are left with the tedious aspects of the work. Thus, as the literature reveals, the worker becomes alienated from the product of his labours and his work is as such de-skilled and degraded (Marx, Blauner).

The place of the craftsman in this process disappears. A comparison can be made to some degree, with the situation in nursing. The 'scientific managers' are the trained staff, notably the ward sisters, and the workers, all those who are not managers, namely the students and auxiliaries. The work is planned by the qualified staff and carried out by the unqualified. From this perspective the student nurse cannot be seen to be an apprentice, she is not learning a skill from a recognised craftsman, rather she is working with a fragmented set of tasks which make up patient care. The price of the loss of

craftsmen, conventional wisdom has it, is a lack of pride in work and a lowering of standards.

'They (scientific managers) have not yet found a way to produce workers who are at one and the same time degraded in their place in the labour process, and also conscientious and proud of their work'.
(Braverman 1974:133)

Whilst this analogy should not be pushed too far as it serves merely to illustrate a tendency toward tedious, and other, work being carried out by untrained staff in nursing, it can be taken a little further. Drucker (1954:284) in a critique of scientific management said:

'It does not follow that the industrial world should be divided into two classes of people; a few who decide what is to be done ... and the many who do what and as they are being told'.

Drucker went on to say that even the simplest of jobs should involve some planning. This, as Braverman points out, was not an entirely new idea for Adam Smith once recommended "education for the people in order to prevent their complete deterioration under the division of labour" (Braverman 1974:39).

The introduction of 'nursing care plans' and nursing according to the Nursing Process could be seen as a means of introducing some decision making and planning element for the 'many' in nursing. (1)
Similarly, the 'theory' which goes into the student nurse training could be seen to serve the purpose put forward by Adam Smith.

Indulgence in analogy can be taken so far as to miss the point of the argument. Clearly, it has to be remembered that nursing is a human service occupation and thus the forms of degradation, de-skilling and alienation, if indeed they occur, will not be so overt as their

1. A problem-solving approach to nursing; this is fully discussed in Chapter 11

counterparts in industry. However, the general principle of enabling work to be done by the less skilled through the supervision of the qualified is one well recognised in achieving nursing work. In Braverman's words:

'Every step of the labour process is divorced, so far as possible, from special knowledge and training and reduced to simple labour. Meanwhile the relatively few persons for whom special knowledge and training are reserved are freed, so far as possible, from the obligations of simple labour. In this way, a structure is given to all labour process, that at its extreme polarises those whose time is infinitely valuable and those whose time is worth almost nothing'.
(Braverman 1974:83)

Braverman was discussing the division of labour in the context of capitalist enterprise. The application of capitalist rationality was introduced to nursing by the Salmon Report. ⁽¹⁾ Carpenter (1977) in a discussion of 'the new managerialism and professionalism in nursing', says that Salmon "explicitly called for a managerial structure based on the industrial model of professionalised management as under advanced monopoly capitalism". This managerialism developed, in the main, at one level removed from direct patient care on the wards. Carpenter points out that in this, formal structure, power, prestige and remuneration are to be found to greater degrees the further away from patient contact one gets. This discussion is taken up in relation to professionalisation in Chapter 11. Braverman's comment on the distribution of knowledge can be said to be true of nursing if one looks at the ward sister, staff nurse and auxiliary nucleus of permanent staff on each ward.

(1) Report on the Committee of Senior Nursing Staff Structure (1966).

The students' complaint that they did not often get a chance to work with trained staff is consistent with the de-skilling argument insofar as trained staff can be seen to be exonerated from simple forms of labour, hence it is left, by and large, to the student nurses. This is how nursing has been made to work. Throughout their training students have been used to the notion of a nursing hierarchy on the ward. Those at the top are seen to be able to do what work they wish whilst those at the bottom must 'get the work done'. This system is perpetuated and justified by the fact that each student passes up through the system to a position when she may, eventually, be more selective in the work she does. It is then perhaps not so surprising that the student nurses are expected to come and go in the de-skilled sector of the division of labour. Nor is it surprising, in the light of this analysis, that the students felt themselves to be evaluated according to their capacity to become efficient workers. Indeed, one might say that they saw themselves to be evaluated as members of the work-force according to their competence as nursing auxiliaries.

CHAPTER 6

'Getting the work done'

This chapter is concerned with the students' description of work on the hospital wards. The students described the styles of management employed in 'running the ward'. Alternative forms of organisation emerged where there was no managerial lead from the ward sister; these are discussed. 'Getting the work done' is explored by looking at 'routines' and the means of supervision employed by the ward sisters. Thus, the category is elaborated in order to explain the students' view of their nursing work. This category is not unrelated to 'just passing through' and 'learning and working'; (1) but its main focus is concerned with how the students do their nursing work on the wards and how the ward organisation presents itself to the student nurse.

In describing the constraints of the ward, as perceived by the students, this account is not intended to present a deterministic explanation of the students' social world. The students, as adults, are able to negotiate, to an extent, their relationship with the prevailing structure and thus come to some working relationship within this. Whilst it must be said that some elements of the hospital social structure are less tractable than others, the students do have a certain amount of manoeuvring room. They should not be thought of as passive objects being acted upon by the social realities which they encounter, in the form of the college, ward staff and patients.

One of the underlying interests in this study had to do with how nursing work organisation, at ward level, impinges on the students. During the interviews the issue of ward organisation was often raised by the students; where this was not the case the researcher

1. Chapters 5 and 9

introduced the topic, in broad terms, by asking how the nursing care was organised on wards on which the student had worked. The question of how ward work is organised invariably led to comments about 'getting the work done' and 'getting the ward cleared'. Clarke (1978) in a paper entitled 'Getting through the work' describes nurses' attitudes towards work in the long-stay geriatric wards of a psychiatric hospital. The present study owes an intellectual debt to Clarke for the notion of 'getting the work done'. This is discussed more fully below.

Running the ward

When asked how the nursing work was organised on the different wards the students commonly said that there were marked differences between the wards. However, as they went on to describe these it seemed that there were some factors common to most wards, as well as individual differences. The following extracts serve to illustrate some of the points.

Student: I think the type of nursing depends on the staff that are there all the time.

K.M.: The permanent staff on the ward.

Student: Huh, huh; they've got an awful lot of influence on, well the way the ward is run. Some wards you have to do certain things and therefore that affects the way you nurse.

K.M.: Can you give any examples - what kind of things?

Student: Back rounds, especially pressure areas, well any sort of pressure areas, even in the same ward you get the different staff; say the SENs do one thing one way and the sister likes to do it another. Sometimes it's very confusing (...)

K.M.: Yes, how do you find that to work with, if you've got to keep changing in one ward it must be difficult.

Student: It's very difficult because like I say, you've got to remember who's on; in one ward I was on if the sister was on you didn't make the beds until after dinner; if the other staff were on (i.e. in charge) you'd to make the beds. (24)

Another student distinguished between different types of ward but then went on to describe individual characteristics of the ward sister.

K.M.: Do you find the ways the different sisters run their wards similar or do you find quite a change from one to another?

Student: Yes, they are quite different, you can't really compare medical with surgical; you have to compare one surgical ward with another, basically the same type of patients. (...) I find the attitude of the ward sister does make a difference. There is one ward where the sister got in a flap about everything, if on an early she stayed on until 7 p.m. (instead of 4.30 p.m.) to see if you are all right; if a student's in charge she was 'phoning all the time saying have you done this etc. That set a guddly attitude on the ward, you never get on. Others are down to earth. The ones who work themselves are good; the ones that sit in the office, people resent them and don't work as well for her, if the ward sister mucks in, it makes a difference.

K.M.: Yes, that keeps cropping up; whether everyone should join in or not - how do you see that?

Student: Definitely should - yes.

K.M.: Do you see the ward sister's role as different from the rest of the nurses or should she be the same?

Student: No, fair enough, I know she has meetings but if you are in wards that are really busy, like the ward sister in Neuro. had time. I don't know how they get to know their patients if they are sitting in the office all day, just can't. I think there are fewer ward sisters like that now; it's the older ones that do less.

K.M.: What about the way the nursing work is organised. When you go on, how do you know what to do?

Student: It's slightly different on each ward. Obviously the basic thing is in the morning they get a bath or bed bath, always drugs and charts to do. And by the time you've done a few years, or a few months you know what has to be done, it's just the order it's done in that differs on the different

wards; you soon get into the way of it. (36)

It seems that however much the students learn in college about individualised care and care plans for patients, as soon as they reach the wards they are confronted with something rather different. They spoke in terms of how the sister 'runs the ward' and whether one sister's ways were like anothers. The students had little difficulty in perceiving the similarities and differences between wards and as the student quoted above says "you soon get into the way of it". The most likely explanation for this ability to get into the way of it lies in the fact that the nursing work is presented to the students in form of sets of routines. These routines can be designed in terms of content by the ward sister. In this way the sister can be seen as the 'scientific manager' (cf. Braverman 1974). This was, however, not always the case. If, for example, a student is told to do a back round she knows, from the similarities between wards that she has to undertake a 'round' of all the patients attending to their skin care. The exact mechanics of how she goes about this will vary from ward to ward, or as we saw above, even within the same ward depending upon who is on duty at the time.

The students also had strong ideas about how they liked to be directed in their work by the ward sister. They spoke of 'good' wards, 'well organised' wards, and some were quite clear about how the care should be organised. In this connection, the students also commonly expressed the opinion that the trained staff should join in with the work. This in fact is interesting, as it gives some indication of how nurses view 'work'; it's exemplified in the case of the student

quoted above, the students equated 'work' with physically looking after patients. The ward sister who sits in the office is thought not to be working and out of touch with her patients. This is consistent with Clarke's (1978:77) findings:

'Both the interview and observation material in this study suggest that the nurses' ideas of what properly constituted "work" involved expending physical energy, doing something during the time they were paid for'.

Styles of management on the ward

It seems, then, that there are several factors which contribute towards a student working well within the organisation of a ward. The way in which a ward is 'run' is, to a large extent, dependent upon the management style of the ward sister. Two distinct types of management were distinguished by the students; one where the patient is the central focus, commonly referred to as patient allocation, and one where the tasks and routines are the main features. The former style was less frequently encountered by the students.

Patient allocation is a way of organising the delivery of nursing care in which each nurse is allocated one or more patients and is responsible for their care. The use of detailed care plans, in which written individualised instructions for the patient's care could be found, was the hallmark of a patient oriented style of management. Clearly, several individual care plans could be combined and translated into routines in terms of the whole ward and thus not all sisters who used care plans also used patient allocation. Pembrey (1978:237) in her study of ward sisters' management of nurses concluded that "the degree to which the ward sister managed the nursing was strongly associated with the degree to which the nursing was organised

on an individual patient basis".

Extracts from interviews presented below are offered in order to give some flavour of the styles of management of nursing work before their implications, for students, are discussed.

K.M.: It just reminded me when you talked about starting the baths and the thought of them being worse than doing them. One of the things that people have talked about is 'getting through the work' and 'getting the ward cleared' and thinking in routines. Is it possible to think of individual patients once you get into the ward (...) or does it become a different way of going about things?

Student: Ah hah; you see I personally feel that the ideal situation in hospital would be one nurse to two patients, or one nurse to one patient, depending how ill they were; and for them to be responsible for their total care. But on the other hand you see, when you do have the grades, different grades of staff, then that's like asking a first year student to special somebody; whereas usually specialling would be done by a student further on. (1) Somehow you have to divide it, how far they can go specialling that patient and how much responsibility is to be put on somebody else. So I think in a way the individual care doesn't happen quite so much, it is hard to do. Especially if you think of a ward with so many patients and it's their time to be bathed so you want to make all the beds; get them all to the toilet and all dressed, sat in chair so you can give them all their cup of tea. You do tend to start thinking like that rather than now I must remember that Mrs So and So needs to have something or other done and she should really have it done before or something like that. Or let's leave her till last.

K.M.: The routine takes over.

Student: Yes the routine, let's get it all done then we'll have time. You never, I don't think you ever really achieve that, we'll have time; it never actually comes. I think it could be more individual, just depends. (...) Critically ill people they are going to be individually bed bathed and so on anyway; so in that respect that's not so much routine that is individual care. Seems to depend on how severe their illness is. (29)

1. 'Specialling' refers to one nurse looking after one, usually seriously ill, patient

This student describes lucidly how the patient centred style of management is the idealised form of care, and all too frequently not realised because of the pressure of numbers and time. The recourse to 'routines' is the most common solution to the problem. Menzies (1960) described the splitting up of patient care into routine tasks in order to protect the nurse from anxiety. This, it is suggested here, might be the real reason for the dislike of individualised care; the data allow no more than speculation.

The two extracts below describe the management by 'routine' style which some students favoured.

Student: I've worked on a ward where the sister had quite definite ideas. I thought it was good. They also had written out like a card with what they called an oral hygiene round as well as a back round. The oral hygienes were done at 10 a.m. and after lunchtime, during the afternoon and after teatime and before they went to their beds at night; which I thought was very good and which I've never seen anywhere else (...) I thought it was good because it's something that's more or less forgotten about in a busy ward, you know the oral hygienes are never done two or fourly hourly, they are never done regularly, it's just when somebody has got nothing else to do that they seem to remember to do them, I found that it was very good (...).

K.M.: You think that by having a few set routines like that it does make sure that things get done rather than ...

Student: It sounds very, laying down the rules, very military-like but I found that it worked well because things get done and you knew that things had been done you know, whereas you're starting something and somebody says 'oh, I've done that'. Nobody knows what anybody else has done and half the time things either get forgotten or they get done two and three times. (23)

K.M.: How have you found the work organised on the ward, was it the same on all or different?

Student: Well the first ward was really unorganised just running around all day trying to get through the work, getting shouted at for not doing this and not doing that. The second ward was all very, very organised, you had this to do then that to do another time, and you did get through the work I think more efficiently.

K.M.: How was it organised, was it written down or ...

Student: No, you were given a report in the morning and allocated to jobs and you had to do, say, all the charts, or you were caring for post-op. patients.

K.M.: Which did you feel happier in?

Student: Personally I felt happier in the ward where it was all in a muddle because I like working where I've got something to do all time and I can't say when I've finished this I just sit down.

K.M.: In the one that was in a muddle did you find that you had more variety of things to do?

Student: Yes; on other I was usually on charts, did dressings once. But on the first ward you did everything, I got an awful lot more experience. (27)

The students appear to sympathise with the underlying principles of patient allocation and tend to view this type of organisation as an 'in an ideal world', style. The fact of a ward full of patients requiring care makes the operationalisation of care seem to the students almost impossible without resorting to routine blocks of care being 'got through' in terms of a workload. As one student pointed out the seriously ill will be given individualised care anyway because of the 'specialling' mode of care which co-exists in a system of ward routines. A patient is 'specialled' when one nurse, usually a senior student, undertakes all the care for that one patient. 'Specialling' is a form of work allocation with which the students were all familiar. Their practical objections to patient allocation were often rooted in their

experience of 'specialling' which is undertaken by a senior student; thus the arguments against patient allocation are based largely on the fact that junior students would often not be capable of totally caring for one patient. Routinised care was favoured by some students because it represented a fool-proof system of getting through the work without items of care being missed out. Indeed, it might be argued that the certainty which a routine provides would also benefit the patients. If an unfailing system of care is in operation then the patient can rest assured that his needs will be met. Just as the students felt that with routines, 'things get done', the patients might gain security from a similar belief. Routines, of course, are only as good as their makers and operators.

Management and non-management

So far, two styles of management have been described, one focusing on patients and the other on routines. Students were very much aware of the presence or absence of leadership in a ward. There were students, however, who described wards where the nursing work just seemed to happen. In other words, there was no overt management strategy coming from the ward sister. This non-management has implications for the organisation of nursing work, insofar as it leaves room for alternative organisational forms to emerge. These alternative forms are discussed later in the chapter.

The notion of non-management emerged as a result of students' comments about the type of ward organisation which they enjoyed. The student who enjoyed the "ward where it was all in a muddle" because she liked to be kept busy. She also got the opportunity to undertake a wider range of tasks than she would have managed in a ward which operated

by 'routines'.

This was not everyone's preference however, as instanced in the following extract.

Student: Well, I enjoy working in a ward where the person in charge knows what they are doing and knows what they want you to do. So you're told beforehand, you know, a certain job and I don't mind being given directions at all, because well at my stage (first year) you can't, you're not in a position to be able to organise yourself that particularly well. So I like to know that the person in charge of the ward is, you know, has got it all thought out and I'm quite happy to, you know, get on with what I'm told to do (...).

K.M.: What is it about that, I mean you sound quite definite that you like it when the person at the top knows what they are doing. How does that affect your nursing?

Student: Well you can concentrate on one particular job and you can get on with it and finish that and then you know that you've got such and such to do. It, well gives you a more relaxed sort of attitude to working because if you are running about all over the place doing lots of little things and you're just about to do one thing and somebody comes and says would you mind doing such and such, it throws me off balance and, you know, you're rushing and probably not doing it properly (...). I think the sister's very important in that she can establish a good ward routine which other people can, you know, carry on when she is not there.

K.M.: What sort of things go in to a good routine would you say?

Student: Well it's sort of having certain things happen at certain times; like how much you actually achieve before you serve breakfast and you know whether patients should be bathed and things like this. So that, you know, you can go on duty, you know exactly what's going to be happening in the morning and you can get on with it and you're not sort of chopping and changing every day but the sister knows things are happening in a logical sequence.

K.M.: So you know where you are.

Student: Yes, you know how much more's to get done before lunch or tea. (5)

Routine care then, can be seen in terms of sets of tasks being performed by nurses in a timetabled order throughout the day; routine in the sense of being a generalised approach to care rather than an

individualised one. By thinking in terms of routines the care of the patients on a particular ward is seen in terms of 'nursing work' to be achieved by a certain time. Clearly, this state of affairs has differing consequences for the patients, the students, the ward sister and her permanent staff. This routine approach to care means that the ward sister can devise her timetable of tasks which can be handed out to student nurses according to their abilities. The students are then able to achieve the work on the basis of 'getting through' their allotted amount. The patient, it seems, does not necessarily receive many benefits through this system, except perhaps, as it was mentioned above, he can be sure of receiving his care. A benefit which should not, perhaps, be dismissed so lightly. There is a case to be made for the patient who is only interested in obtaining efficient nursing care; without any of the socio-psychological overlays which come with the individualised care ethic.

Student: I think the patients must sort of feel they are on an assembly line; first of all they get their beds made, then washed or bathed, oral hygiene. Don't all get everything done at once - there's no way you can do that - can't go back and forwards, you would have to have everything out (i.e. necessary equipment). (...)

K.M.: What do you think of that as a system?

Student: It's OK for me, I don't know how the patient feels. (28)

The idea that the ward is run to suit the needs of the staff rather than the patients was a recurrent one. One student pointed out that it was only as she got on in her training that she came to realise that the patient had to come first.

K.M.: Have you seen different wards being organised in different ways, the ones you've worked on so far, have they got much in common or are they very different? (...) is there anything you can carry from one ward to the next or are they ...

Student: No, there is an awful lot that you can carry on that you pick up. I think the main thing is that as you get on in your training you realise that your patient is the most important thing. I think with my first wards I tried to impress, well not show off impress, but I tried to create a good impression and hopefully I thought sister will think I'm a hard worker and I'm caring. When we were busy I used to become harrassed if the patient was being slow and now I feel I'm totally changed; sister can just wait, this patient is taking her time, fair enough she's ill (...) a lot of basics you just carry through, routines and everything.

K.M.: So how do wards differ from each other then? Do different sisters have different ways of organising things?

Student: Yes, some are a lot more trivial than others. In the majority of wards you go and take a sphyg(nomanometer) round and put thermometer in mouth, in one ward you have to get a trolley for the case notes and sphyg.(...) and the sister goes mad if you don't do that. Just these trivial things that annoy you that you see no reason for and don't understand.

K.M.: How do you find out what to do, which trivial bits suit?

Student: Either a S/N or a student tells you or you get a row from sister it's as simple as that (...) you learn as you go though, some are so strict about aseptic techniques and others aren't. (21)

This student pointed out that a lot of the wards had much in common and that often the matters which present the students with problems of adjustment from ward to ward are trivial. Her comments about putting the patient first, now that she is a senior student, should perhaps be treated with caution. Whilst she was not the only student to make this point, there is always the possibility that such remarks are made in order to impress the researcher. Taken at face value it seems that this student had initially put the organisation and ward routine first, not least because she was attempting to impress the ward sister; only when

she became a more senior student did she put the patient first. Clearly, this possibility of 'impression management' is one which persists throughout a study which employs this method. Any such piece of research is founded on trust and it must be taken on trust that the data were offered and gathered in good faith. Attention is drawn to the question of impression management here because in this particular extract it does show the student in a favourable light, one which she might well have manufactured. The fact that she was not alone in claiming to have become more assertive as she progressed through her training adds to the credibility of her comment.

Alternative organisational forms

The provision of guidelines by the ward sister is not, of course, any guarantee that they will be followed. One student said that "a lot of the good wards have care laid down, ... others the care given is optional - so how good the care is depends on the student nurses on the floor". If a ward sister does not supervise and issue guidelines the care falls into the hands of the students on the staff. As it has been mentioned above this can be organised along the lines of the official hierarchy or the social structure of the ward - structures which are by no means independent of each other. Indeed, the interaction of the official hierarchy and the prevailing social structure is an important point to consider. Although, as has been argued, the student's position should not be seen in deterministic terms neither should it be thought of as being entirely the result of negotiation. The nursing hierarchy is a social reality with which the student must contend; and its presence has implications for her negotiations within the social structure of the ward.

The hierarchy which exists in the nursing structure is evident on many wards. This fact is relevant to the discussion insofar as the kinds of tasks carried out by the individual students on a ward, which does not have specific routines laid down by the ward sister, are often dictated both by their position in the hierarchy and their relationship with the permanent staff on that particular ward. The given hierarchy can be used as a dependable substitute for any more imaginative division of the work which the ward sister might have devised in her routines. The category 'learning and working' is closely linked with this concept and is described elsewhere. The use of the hierarchy, in terms of the who does what in the organisation of ward nursing, was summed up neatly by one student who said: "If you are a staff nurse you don't get a bedpan, if you are a third year you don't get a bedpan - if you have no stripes - you've got the bedpan".

The ward sister is the person who sets the general tone of a ward and decides how the ward should be organised. At least, it is true to say that it is generally premised that the ward sister controls the ward. However it is clear from these data that the way in which nursing care is actually organised at patient level does not always accord with the directives of the ward sister. This is the case because the ward sister is only one of the several people involved in the delivery of patient care. The ward sister operates according to her own ideas about running a ward, yet, she does this in the context of a nursing hierarchy, from auxiliaries, through the students to her staff nurses. The students are, generally speaking, a malleable breed who are used to obeying ward sisters' instructions; the trained staff and auxiliaries are in a different position vis-a-vis the sister and as such form a

social sub-structure with which the student must contend. Thus, although the ward sister is ostensibly the person who dictates how the patient care shall be given the forces in operation beneath her can have a profound effect upon how the ward works. This is true of circumstances both where the sister manages and does not manage the nurses.

There seemed to be several options, not necessarily mutually exclusive ones, pertaining to how the ward was 'run'. The sister as the official leader could adopt a firm role and control the nursing work either by patient centred or routine task centred methods. In running her ward, the sister had to have some means of exposing her style to her staff and students so that they could know what was expected of them. This exposure could take a wide ranging form, from the very overt tactics of work books, closely prescribed, supervised and accounted-for care running either along individual or routine lines, to a total lack of direction from the sister, in which case other mechanisms came into operation. Students gave accounts of both task centred and patient centred organisation of nursing work. Some students expressed a preference for patient centred nursing but readily accepted the necessity for a routinised approach because this was the way to get through the work. Knowing what to do and being occupied were central concerns for the student nurse, and active management by the ward sister fulfilled, on the whole, both of these needs.

If direct supervision was not given by the sister the two major alternatives lie in either the official organisational hierarchy coming into play when staff nurses, enrolled nurses and senior students more or less decide what will happen; or the informal social structure is

used to bring some order to the work. This sub-culture which can develop quite strongly on a ward or among a group of students then becomes the major organisational force which ensures delivery of patient care. The effects of both the official hierarchical structure and the informal social structure which make up the ward climate are discussed below.

The situation in which the sub-culture rule is allowed to emerge was typified by one student who said:

'Obviously people's ability to organise varies a lot - some wards are very well run, you know exactly where you are; at report each person is told who to work with and what to do (...). On other wards everyone scatters after report and does their own thing'. (8)

Everyone "scattering" with no directives from the ward sister leaves the path open for some other means of running the ward coming into effect. Several students mentioned that if they worked on a disorganised ward the students often got together and organised themselves. This type of student co-operation is all the more effective if the students are from the same set or are friends outside the hospital, as was sometimes the case. This sub-culture approach to organising patient care is dependent upon either the hierarchical nature of the official organisational structure on the ward or the co-existent social structure. The importance of the social structure was highlighted by one student who said right at the start of the interview that she always likes to know who she is working with for the shift.

The permanent staff of a ward, that is the trained staff and the

auxiliaries often formed a social group of their own and ran the ward on the basis of this informal structure. As it has been said, a common complaint among the student nurses was that trained staff, especially staff nurses, often left the students to do the work whilst they enjoyed prolonged coffee breaks in the office. It was during the discussions of ward organisation that the question of whether the ward sister or staff nurses when they are in charge should join in as part of the nursing work-force on the ward.

K.M.: Have you got any preferences for the way some of the ward sisters have organised the way the actual nursing is carried out, who does what etc.?

Student: Not really. I like when the staff nurses help in a ward and ward sister helps as well. You find in a lot of wards the staff nurses go and drink coffee and things like that, if the ward isn't that busy and the students are left to get on with all the boring tasks, like a care round. I think with a care round, well, it's up to the whole of the ward team to try and help, because it can be so heavy and take so long. When it comes to charts and things I think the staff nurses should help as well because you find in casualty and theatre the staff nurses are great at helping; it's them in charge. In wards you sometimes find it's the senior student in charge because the staff nurse is always in her room; she may have the doctors, the report and a lot of paperwork but I still feel that in a lot of cases they could try and come into the ward and mix with the patients, if not with the staff. (21)

The fact that the work is 'heavy' was often the main reason put forward by the students for wanting the trained staff to join in and help out. This is consistent with the students' notion of there being a job to be done and their desire for an 'all hands on deck' approach to doing it.

Clarke (1978:78) found a similar attitude to nursing work:

'Leaving aside what they would have liked to do, the main aims of the nurses, in particular on the long-stay wards, centred round getting through the work, work being defined in terms of physical tasks. The language they used to describe the work emphasised this: "the work load";

"working hard"; "pulling your weight"; "pulling together"; "mucking in" (...)'.

The student quoted above referred to the tasks which the students were left to do as "boring tasks" and gave as an example the care round. It is interesting to note that the particular task, which she dismissed as "boring", is one of the number of nursing activities which can be said to be independent of medical orders. Thus whilst there is a move to increase independent nursing activity and develop a 'body of nursing knowledge' to this end, the very practice of this nursing is here regarded as boring and left to student nurses. The idea of steps in the labour process being divorced from knowledge and thus allowing the labour to be carried out by less qualified personnel (Braverman (1974:83) is relevant here. The staff nurses and sisters could be said to be adopting the role of overseers with the necessary knowledge for planning and ordering care, whilst the students see the behaviour of the trained in terms of their shirking the 'boring' tasks. Boring tasks, incidentally, are not deemed to require knowledge for their performance, as evidenced by the perceived interchangeability of students and auxiliaries.

Routines

Routines were considered by the students to be, to an extent, inevitable if care is to be rendered by institutions. Patients are categorised according to medical condition and care is dealt out in routinised batches by both medical staff and, following their example, by the nursing staff. By the nature of things many of the needs of patients are held in common, the normal functions which they generally perform for themselves according to what might even be considered to

be a fairly common timetable must be met by the institution. Thus, eating, washing, and sleeping times are scheduled according to the hospital's idea of an average day. Routines are problematic on two main counts, firstly, they very readily get out of step with their purpose and thus begin to meet ends other than those for which they were primarily designed. Secondly, routines are to an extent all absorbing. If some matters can be dealt with routinely, why not others? Routine then becomes the only line of approach to any task or situation. In the latter case routines can become petty and irritating, seemingly serving no purpose other than the proliferation of routine; this in particular is a problem with hospital or ward routines.

Ward routines can be described in terms of external and internal routines; the former are those which are imposed on the ward from the wider hospital context, examples would be meal times, visiting hours, doctors' rounds. The distinction, it must be remembered, is an analytic not an empirical one. It merely serves to clarify a discussion of the data. Internal routines are those which are specific to and within the control of the ward, such things as when patients are bathed, ward reports given, etc. Axiomatically the external routines put constraints on the organisation of each individual ward and thus dictate or at least limit the scope of internal routines. From the point of view of a student nurse, however, the concept of a routine is an important one; she is able to distinguish the organisational style of one ward from another largely on the basis of its routines. External routines, once grasped can be transferred from ward to ward, whereas internal ones

must be learnt afresh each time. All wards are in some senses similar to each other and in others they are different: it is the external routines which make them similar and the internal ones which make them different.

The notion of 'getting through the work' was frequently linked to the idea of routine on a ward. The idea of a certain amount of work to be got through before a certain time was common. If nursing is conceived of in these terms it rapidly becomes an activity apart from caring for patients. 'Running the ward' takes on its own character and although in the first instance strategies for organising patient care en masse were developed of necessity there is a tendency for the machinery of organisation to take over. The essential nature of nursing can be sacrificed to the organisation of care, which is indeed ironic as the patient, the object of the care, is the *raison d'être* for the organisation itself.

Getting through the work in this routinised way appealed to those among the students who enjoyed the 'pace' of the work. Some of the students expressed a liking for 'being busy' as distinct from 'looking busy' which is illustrated in the extract below. Surgical wards were often preferred to medical wards on the grounds that they were "more exciting, a larger turnover, quicker pace".

K.M.: One of the things that keeps cropping up in these interviews is people talking about 'running the ward' and 'getting the work done' like you said a list of tasks to be done, it never seems to bear much resemblance to the total patient care bit that you get in college. Do you find a big difference?

Student: Oh yes. College is obviously to the book. You go to the ward and everybody does their own thing. I find that as well, as long as you get through the work; it doesn't matter about the patient, you've done your work. In (...)

if you sat down and talked to patients, which is what they need up there even as a junior nurse you can talk, they (the staff) get really mad, you should be working sort of thing. But you are there to talk to the patient as well (...)

K.M.: Even there that wasn't seen as doing something. You have touched on something else which crops up - this constant looking busy even if nothing to do.

Student: Mm mm.

K.M.: Where does that feeling come from, does anyone actually tell you that you must always do something?

Student: No, it's just they look at you 'now what are you doing nurses just standing there you should be rushing and looking as if you're working'. It's always the impression you get. I've never been anywhere where they allow you to stand around if there is nothing to do; you have got to do something. (8)

It is interesting to note how this student makes the distinction between doing the work and looking after the patient. She also pointed out the need to be seen to be busy which many of the students discussed. Again this is consistent with Clarke's (1978:79) findings:

'Talking or listening or waiting for a patient to do something for herself, are regarded as less work-like than "doing" something for the patient such as dressing or bathing. Some of the patients shared this view, "you'll catch it, haven't you anything else to do?" they joked with nurses who sat down and talked for any length of time'.

The notions of being busy and getting through the work seem to be tied to the question of for whose benefit is the ward being 'run'. Routines are tied to the shift system of hospital nursing and the amount of work to be done through the routines was often timetabled according to the hospital shifts. The division between night and day staff is well recognised in nursing. The students referred to the clash of routines between the shifts which often run independently of each other. An example was given of back rounds or oral hygiene rounds being carried

out in quick succession, that is at 8.30 p.m. by the day staff, repeated at 9.30 p.m. by night staff. Similar clashes were described in the mornings.

The overriding consideration between shifts seemed to have to do with getting through the work which was considered to be the province of one shift before the next shift arrived on duty. This aim was often strived for irrespective of the unexpected events of one shift, which might have put the routine behind schedule.

Much of the rush and adherence to routine could be attributed to the general uncertainty of ward life. If there is at least one thing which can be relied upon, namely the routine, other calamities can be coped with in some way. This uncertainty factor is a fairly sound justification for the hurried nature of nursing work if it is considered within the context of individual shifts, and this, according to the students, does appear to be how the work is thought of and divided up. The nurses are continually working quickly in case the unexpected crops up and throws the schedule routine out of phase. The rush, after a crisis, which is necessary in order to remain on schedule, is anticipated and employed before any crisis occurs in a 'just in case' sense. Thus, nursing care is carried out in a series of hurried routines with a sense of only just keeping ahead of time in case some delaying event should arise. Clearly, if there were not seen to be such rigid divisions between what work is appropriate for one shift to do as opposed to the next, this rushed approach to nursing would be redundant. The routine would then cease to be the driving force rather it could become an organisational tactic for ensuring that nursing care was given in an unhurried manner.

Routines, it must be said, should not be dismissed out of hand. Davies (1976) argues that nurses have pursued a rather different occupational strategy from that which seeks to professionalise. The strategy includes "subordination to doctors, acceptance of a wide range of tasks, and, in particular, routinisation of their work". In her discussion of the routinisation of work, Davies claims that nurses are seemingly satisfied with this. Davies accounts for all three elements of the occupational strategies adopted by nursing by setting them into an historical context, but she poses the question: why do they persist? Routinisation of work:

'serves to lessen stress. The consequences of error can be severe, the witnessing of pain can provoke considerable anxiety for the nurse and routine behaviour and subordination can help solve these problems by depersonalising a situation (Abel-Smith, Menzies)'.

More intriguingly Davies suggests that routinisation of work actually helps to maintain subordination of the nurse to the doctor. Davies also comments that routinisation of work

'has been noted as a solution in situations of high turnover. The familiarisation of newcomers is much facilitated where procedures can be relied on to be identical where channels of reporting and limits of responsibility are set'.

This last function of routinisation, whilst recognised in the present study, is not entirely borne out. The discussion is expanded in the consideration of the category 'just passing through' (Chapter 9).

Discussion

The division of opinion which exists about the overall desirability of routine versus individualised approaches to patient care has implications beyond the simple question of - does the patient receive his care? It raises issues of delegation and accountability,

professionalism in nursing and the place of professionals or future professionals (the students) in the context of an organisation.

As it has been suggested above, routinised, carefully prescribed care can, to a large extent, obviate any need for the exercise of professional judgement on the part of the care-giver. If the nursing work is organised along individualised, patient allocation lines, then the questions of use of professional judgement and discretion on the part of the nurse are more likely to arise. In concrete terms, in the routine-style organisational setting the nursing work could be labelled "charts, dressings and water jugs" for one nurse; and "bedbaths and oral care" for another. In the individualised care system one nurse may be given Mr X, Mr Y and Mr Z whilst the other nurses are, also, allocated a group of patients. Clearly, if the work is allocated in this way the room for the use of discretion on the part of the student is greater in the latter case. Although it should be remembered that the care plans for Mr's X and Z might well spell the care out in some detail and thus decrease the discretionary potential for the student nurse.

The students appear to require a certain amount of independence in their work, yet they need to be sure about what is expected of them in order to exercise this discretion. The notion of discretion has to be set against the overall pattern of ward organisation, and the nursing hierarchy. Discretionary limits can be set to students work whether they are involved in a system of individualised care or task-oriented routinised care. The question of direction and supervision proved to be a moot point among the students. Broadly, it could be said that the more senior students began to resent supervision as they became

experienced, whereas the junior nurses appreciated it. This, indeed was not a surprising discovery. The consequences of the presence or absence of ward sisters' dictates are, however, of interest. If students are to become qualified practising nurses in their own right they do need supervision and aid in order to attain this status. By the same token if care on a ward is to be organised as a communal activity trained staff and learners alike must follow the directives of one overall controller, namely, the ward sister, although it must be said that with the shorter working week the ward sister is absent from the ward for a large proportion of the time. Difficulties arise firstly, if the trained staff wish to exercise professional autonomy and make their own clinical decisions on the basis of professional experience and judgement. Secondly, if the senior students wish to flex their muscles in this same direction. Clearly, the second consequence is more easily contained as the learners do not have the authority upon which to act independently. It does, however, raise interesting questions about the training of nurses, organisation and the exercise of the professional judgement to which, as registered nurses, they must lay claim.

The ward sister is faced with patients to care for and an unqualified work-force with which to effect the care. The question of supervision of the students' work is therefore a crucial one. It seems that there are at least two alternative types of solution to the problem of supervision, namely, bureaucratic and professional. The ward sister may well feel justified in resorting to the tactic of degradation of the work; that is to say divorcing it as far as possible from specialist knowledge and reducing it to simple labour

(Braverman 1974), in order that the students might carry it out. Insofar as the students saw themselves to be interchangeable with the auxiliaries in the work-force this tactic has a degree of plausibility. That is, until we consider that the student nurses are moving towards a position when they too will be qualified and, if the professional model is accepted, they should carry out their nursing work on the basis of their knowledge and professional judgement. The difficulty with this lies in the fact that the students have had no experience during their training of exercising professional judgement, by virtue of their student status.

It could be argued that the ward sister's recourse to this division of labour approach to achieving nursing care stems from the fact that it is in terms of groups of tasks, rather than on the basis of any professional judgement, that she has always nursed and thus still plans care along the same lines. In other words, to suppose that the student is progressing towards attaining a position from which she will nurse according to professional modes of practice is a false premise. Perhaps the ward sister organises her care by employing an hierarchical approach to allocating nursing work for the simple reason that she has not moved on from this conceptualisation of nursing organisation since her own student days. One conclusion drawn might be then that students are being taught in the only way that the sister knows which she also picked up as a student nurse, namely to divide patients up into entities of care which are graded and carried out by students of appropriate seniority, or indeed by auxiliaries of sufficient long standing.

As it has been suggested earlier there are difficulties involved in accepting the professional model for nursing which takes place within

the hospital organisation. The co-existence of a bureaucratic hierarchical management system in nursing and the fact that several qualified nurses may work together at one time in the same ward creates a contradiction which must be resolved. Resolution could be achieved if the individual staff nurses are given both authority and the attendant accountability for the care of a number of patients. In this way each qualified nurse can exercise her own professional judgement and work accordingly. The evidence of this study suggests that this style of management is rarely encountered, although it is beyond the scope of the study to say any more than that.

The issue in question has to do with the work of professionals within organisations which are run along bureaucratic lines.

Stinchcombe (1959), in a study of construction work, argued that:

'the greater degree of professionalisation of its labour force enables the construction industry to function with a minimum of bureaucratisation. The workers employed are for the most part skilled craftsmen who can perform their tasks without much direction and control from superiors because their work is guided by standards of craftsmanship which are akin to professional standards. In short a professionalised labour force constitutes an alternative to the bureaucratic organisation of work'.
(Reported in Blau and Scott 1963:208)

If we accept for the moment that nursing is a profession, then Stinchcombe's remarks concerning the construction industry have some relevance for nursing. Also, nursing carried out along "standards of craftsmanship" lines, or even professional lines could provide a more sanguine outlook for the student nurse. If 'craftsmen' are to be found in the wards then the student may well be apprenticed to them in a rather more satisfactory way than the present as the data of this study suggests (as discussed in Chapter 5).

The questions of professionalising and professionalism are addressed in Chapter 10. The data discussed in this chapter in relation to the category 'getting the work done' lays much of the groundwork for a discussion of profession and nursing. For, thus far, the main argument has been that nursing is conceived of as work to be 'got through' by a work-force of student nurses and auxiliaries whilst the qualified, 'professionals', look on from their position as managers. The process by which the nurses discover how to 'get through' on the wards is the subject of the next chapter.

CHAPTER 7

'Learning the rules'

This category emerged from the data concerned with how the students discovered what was expected of them on the hospital wards. The students described how members of the permanent staff made their expectations of the students known. This process of finding out and reacting to staff expectations is the concern here. Broadly, this category can be said to explain the data concerned with the occupational socialisation of the student nurse, as it were, 'on the job'. The data in this category are most appropriate to the reaction approach to socialisation, that is to say following Olesen and Whittaker (1968) and Becker et al (1961) the student, rather than the professional role is the central focus. The notion that the students react to the process which they are experiencing and negotiate their role and behaviour accordingly (Simpson 1980) seems to be relevant here.

The following discussion is concerned with several interrelated themes which, together, form the substance of the category. Stated briefly, the argument is, that student nurses were very soon made aware of what was expected of them in terms of speed, and accomplishing a sufficient share of the nursing work by 'pulling their weight'. Social control on the ward and the concept of unwritten rules of the ward are explored within the context of occupational socialisation.

If the occupational socialisation of the student nurse is to be examined it is necessary to first question how the students perceived both the nursing role and its acquisition. Merton (1957:287) summed up the process of socialisation thus:

'the process by which people selectively acquire the values and attitudes, the interests, skills and knowledge - in short the culture - current in the groups of which they are or seek to become, a member'.

This definition was given in relation to the socialisation of medical students, Merton suggested that socialisation takes place primarily through social interaction with people who are significant for the individual, namely the staff of the medical school, fellow students and other hospital personnel. In the case of the student nurses in this study, the permanent staff, trained and untrained, of the wards and the other student nurses appear to have been the significant people in this respect. Thus, the question of how the students acquire the role is rather more easily addressed than how they perceived the role of a qualified nurse.

The students' notion of 'nurse'

The researcher asked the students about their ideas with respect to what a nurse should be; this topic often arose when the question of the 'ideal' nurse or the stereotype nurse was under discussion. Some of the students said that they had not expected nursing to be as it is, yet they found it difficult to describe what they had expected. Thus the data concerning the students' image of an ideal nurse are by no means exhaustive but worthy of comment as an introduction to the category.

One student typified the position of many when she talked about the 'student mould' that the staff expect students to fit into.

Student: Well I'd like to be able to sometimes do things that you want to do in the ward, not to have everything, you know, got to just fall into the mould all the time that a student should be and just do that (...)

K.M.: So what's the student nurse mould that you say you are supposed to fit in?

Student: Just sort of doing what you're told and sort of not questioning. I sometimes feel the nurses, the student nurses who do that are much happier - just looking round at them - they are much happier because they don't create any problems and they don't get into trouble - not that I have, I've always been very lucky. But they don't have so many problems, they must go puppet-like about their work and don't question anything, don't understand it. If you don't understand why you're doing the thing - I don't see the point of doing it. (32)

This student recognised the stereotype student nurse image when she said that they "fall into the mould". The students suggested that the permanent staff on the wards did not regard them as individuals, rather as part of a work-force made up of different grades of nurse. Thus, so long as a ward has its complement of junior and senior students slotted into the available spaces, the students need not be thought of as individuals. Indeed, the student quoted above suggests that the student finds her life easier and happier if she fits into her slot unquestioningly. The attitude of the permanent ward staff, as described by the students, is perhaps not too surprising. It is a reasonable response to the labour situation which confronts them. Thus, whilst the students might find this reaction to their presence on a ward annoying, and describe it in terms of a complaint against the ward staff, it is, from the ward staff's viewpoint, a rational response to the fact of mobile student labour.

Another student explained how she came to terms with being a student nurse when she said that at first she did not know how to react in a hospital. This feeling of not knowing what to do or how to behave was common to many of the students. The following extract is part of a discussion concerned with feeling more at home in the hospital, and illustrates the point:

Student: I don't know, you are just more relaxed in the environment, I think. Because when I first started off ... maybe because you don't know the ward and you don't know how to react in a hospital; you get used to it, even if its a new ward, just because you know what the hospital is like or you've worked there before, or even you know the kind of routine of most wards. I think you relax more yourself and it makes it easier to talk to somebody, whereas if you are a stranger yourself its slightly harder.

K.M.: You said you didn't know how to react in a hospital, how have you learned to do that?

Student: I don't really know, I suppose its just come from experience; before I was petrified of hospitals even if I go to see somebody in a hospital I'm quite scared but I think when you work there ... if I was in hospital myself I'd be slightly nervous but because I'm working there I know how to go about it, you're more relaxed (...) You do copy the older nurses in a lot of things you do, how you explain things and how you listen to a patient. I think you copy a lot of people, I suppose it must be from copying other people - but to behave as a nurse I don't think anybody knows how to do that you don't imagine yourself as a nurse on a ward, you know you are a nurse but ... not many people think of it at the time.

K.M.: You mean the public image of the nurse you don't think of yourself as ...

Student: Yes, the kind of Florence Nightingale thing. Nursing is not what I thought it would be; (...) it wasn't what I'd gone into. You just kind of imagine something and its not what its like so you don't imagine what you're doing is nursing ... doesn't follow story books you read when you're younger.

K.M.: Can you say what you expected?

Student: Can't really; just imagined it all different, I think its very academic, you really have to be intelligent to be a nurse which I think is very wrong. Because there are a lot of good nurses that aren't intelligent but people who are kind, know how to handle people and relax them (...) (39)

This student talks about copying other nurses, many of the students mentioned this behaviour, often in relation to copying other students. However, she still maintains the idea that there is a way which is acceptable for a nurse to behave even though she does not claim to know what it is. The idea of a public image of the nurse was popular with the

students. They said that the patients have preconceived ideas about how a nurse should behave and what she should be like. The image that the patient has of the nurse was often thought to be quite important for the student nurse's self esteem. If the patient thought that she looked competent and knowledgable then the students said that they were more likely to feel competent. As in the case of the student above, who had a rather romantic notion of nursing, many students did not feel ready for what they encountered in nursing. The question of whether nursing is too academic or not sufficiently so was raised several times by the students.

Occupational socialisation

The following themes which emerged from the data, underscore the idea that the students were taking on the role almost on a day to day basis. The notion of anticipatory socialisation occurring during the three years as a student does not appear to be useful in the light of the students' descriptions of their experience.

Following Olesen and Whittaker (1968) and Becker et al (1961), it seems reasonable to suppose that the students concern themselves with adapting to current situations rather than preparing to take on the role of qualified nurse in the future. Simpson (1980:12) in defending a combination of induction and reaction perspectives on occupational socialisation argues,

'followers of the reaction approach reject the inculcation of guiding norms and attitudes as an explanation of behaviour in future situations, partly because the future is unknown until it is experienced, but more fundamentally because this approach sees behaviour as emerging from the transaction between self and exigencies of situations'.

The students were introduced to the expectations of their role almost as soon as they began to work on the wards. The permanent staff, it seems, wasted no time in letting the students know that they were expected to 'pull their weight' and to 'get through the work' in as short a time as possible. The students spoke of the speed with which they were expected to work on the wards which did not compare with the ways they had been taught in college. The way in which the students spoke of the need for speed demonstrates just how real they found the pressure from the permanent staff, to conform. The students, whilst on the one hand knowing what they had been taught in college, were prepared, on the other, to justify the hurried approach to ward nursing in the same terms used by the ward staff. This was exemplified by one student during a discussion about there not being time for the sister to teach on a busy ward:

K.M.: And you are left to find out for yourself in wards where they are understaffed and so they don't have time to teach.

Student: Yes. Fair enough in geriatrics, that's where you can really learn your basic nursing care, the care of the elderly patients, you have the time to take time with a back round and do the full ward in an hour and a half because there's nothing much doing in geriatrics. Whereas, if you go up from geriatrics to a busy surgical ward, the junior nurses still take the amount of time to do a back round, which you can't do if you've got a busy theatre list, you're admitting emergency patients and they (the juniors) are needed for somewhere else to do another job and are still doing a back round. Its just not on (...). Its adaptability, you've got to adapt to your ward situation where you can take your time and where you can't (...).

K.M.: So the difference you are talking about is the speed with which you do the back round, not that you do anything different, is that right?

Student: Its the speed. You can take your time in geriatric wards or wards that aren't busy. But the same list you do goes on up in surgical as it does in medical. You can take your time in a medical ward, but the minute you go up into a surgical ward you've got to learn how to do that in a flash (...). (4)

This student had not only adopted the permanent staff's rhetoric and explanations for the speed of work, but she also supported the idea, and was prepared to uphold it in front of junior nurses. In a sense, she can be said to have been fully socialised into the nurse role in accordance with the wishes of the permanent staff. She had not only taken over their attitudes towards the work but was prepared to hand them on to other students.

Not all students were so prepared to go along with the notion that nursing at speed was not only necessary, but a good thing. The following extract puts this alternative viewpoint.

Student: (...) I've been told it takes seven minutes to do a bed bath. If they are not finished by 10 a.m. you are falling behind. We should be allowed to do things in the time they take to do. I've been on wards when I suddenly think, I'm being slow; there mightn't be any other pressures or other things to do, but I take time because that's the way the ward is going.

K.M.: The sort of pressures you are talking about, these are hard to define in some ways aren't they? For example, you could have a sister who says you must be done by 10 am. and you still have two legs and a bottom to do. But again, even if there isn't a sister who is hurrying you up do you sometimes feel like you said just then - 'I'm being slow'. What is it that's pushing you then?

Student: An alarm clock inside, probably just your own personal feeling of what others think of you.

K.M.: This comes back to what you said earlier about 'the nurse' would do it quickly (as opposed to Nurse C...)

Student: Yes, you hear some nurses are slow. They may be, doesn't mean she can't be a good nurse. I've seen these mad machine nurses, I'm thinking of one now, its like a production line. The staff nurse recently started on a medical ward - a very easy going ward, you feel free to do your work properly. I'd do bathing with her, I'm not a fast bather - what's the point - bathing with her was like a competition. Like one of these old films speeded up. The patient maybe chatting away and her not really listening to a word saying yes and no maybe; totally within herself. I felt she was working to make it look good in the front office. (7)

The above extract illustrates several interesting points from the data. This student did not value speed, indeed she could not see any patient benefits from working at such a pace. However, she clearly recognised that it was a trait which did create a good impression in some nursing circles. She suggested, for example, that the "mad machine" staff nurse was only doing the amount of work that she did in order to impress the nursing hierarchy, the "front office". She had worked in wards where, she felt, the timetabling of the care was strict, even going so far as to time bed baths. Yet, she could still feel pressurised into hurrying in her work when there was not any overt pressure being brought to bear. The "alarm clock" inside her was a point which, in one way or another, a few of the nurses made; it was mentioned sometimes in the context of junior and senior student nurse behaviour. A third year student claimed that she had become much more likely to defend her behaviour as a senior student than she might have been at the start of her training. In the following abstract this point about "the alarm clock" was pursued by the researcher.

K.M.: Do you find there is a sort of feeling in nursing that if you are fast you are good, it doesn't matter how you do it so long as you get it done by ...?

Student: Yes there is a feeling, I don't think its necessarily right but there is. I mean everybody likes being on with staff nurse who is going to have the ward all in order; and sister is going to come on and everything's going to be done, towels are not on radiators, soap not wet in the lockers and clothes not hanging out of the doors - it doesn't really make that much difference to patient care, you know! Everybody likes, I mean its just the usually accepted way, the ward has got to be tidy (...)

K.M.: In some of these interviews we have talked about this kind of thing, and its often quite difficult to pinpoint why people feel like that, its not necessarily that someone keeps saying

'you must be quick' - but the students say they feel that they are looking over their shoulder all the time and think 'I've been in here a long time, I wish this patient would hurry up'.

Student: Yes you do, you do.

K.M.: And I wonder where that comes from, there is a sort of stereotype of a nurse that should be fast.

Student: I think, well there seems to be and the more junior you are the more I used to try and fit into that category but now I turn round when somebody says 'what have you been doing in there?' I still keep the speed up to get as much done as I possibly can, if I've been in for a long time, and, say, a patient starts crying or something, you can't just say 'oh, shut up' - you can't really say that. You say so and so is upset so I stayed rather a long time in there and that's that. I've got to the point where it really doesn't bother me, if someone says 'you've been in there for ages' - I just say 'too bad'. (32)

The comments of the last student demonstrate, not only how the student nurse might become more adept at defending her own behaviour as she becomes more senior, but also, and more importantly, that the need for such defence clearly exists. Her description of the tidy ward in which everyone likes to work and the idea that 'speed' somehow equates with 'good' in nursing exemplify the feeling, among the student nurses, that such a thing as an 'ideal nurse' or at least 'ideal nursing' exists, if only in the form of some distant grail.

'Unwritten rules'

The students found it difficult to explain where the idea that nursing work should be done quickly, came from. As a result of exploring this theme the notion of 'unwritten rules' of the ward emerged. These rules were not overt, but were made known and enforced by more subtle means. Stated briefly, the 'unwritten rules' said that students should work quickly and 'pull their weight' in doing a fair share of the work. Moreover, if there was no work to be done they should endeavour to 'look

busy' in order to preserve the overall atmosphere of activity and efficiency.

At the early stages of the development of the 'unwritten rules' dimension of socialisation category the researcher asked one student in the course of a discussion of ward organisation:

K.M.: Is there an unspoken set of rules ...

Student: Yes.

K.M.: Of the way you are meant to behave in a hospital?

Student: Very definitely yes. I think there is.

K.M.: How do you feel them if you don't hear -

Student: Just from looks you get, if things are out of place they just look at you, just find out not from asking anybody its just there somehow, you just know it - that's accepted and that's it. People sometimes emit it so strongly that you just know that you don't do that sort of thing.

K.M.: A little bit like doing everything in a hurry -

Student: Everybody normally works in a hurry so you had better not do anything else. (7)

The student quoted above put into words the way in which the 'unwritten rules' are enforced. The fact that the student felt that all the staff needed to do was to give a 'look' in order to ensure that the student toes the line, indicates that there is a fairly clear and universal understanding within the wards of the expectations associated with the role of the student nurse.

The concept of 'pulling ones weight' arose again in this context. It has been described in Chapter 6 (cf. Clarke 1978). In the context of how the students are socialised through their interaction with permanent staff, 'pulling your weight' in order to 'get through' the work are both pertinent concepts. The students talked of the need to demonstrate that

they were 'doing well on the ward' and their surest way of achieving this was to 'pull their weight'. Students could recognise instances when another student or a member of the staff was not doing their fair share of the work. The extract below illustrates this point:

Student: You can maybe have one staff nurse or one enrolled nurse that does feel themselves above everyone (...) she spends half the time in the office, before we had even had report she'd be writing out the menu cards while we are trying to give out breakfasts, then rush into report and rush out again to get them all to toilet (...). It was resented by everyone on that ward just one particular nurse. On the other hand, she was one who did a lot of caring. She didn't do much of the hard grind stuff, but if there was someone seriously ill she would sit with them which is important. On the other hand people would say 'why is she just sitting there when we have all this to do?' You have your priorities but she never pulled her weight whether there was something that need done or not (...). Mucking about with forms, discharge papers, files etc., when there was work to be done. She was only one, most of the staff were in there with their sleeves rolled up just the same as us. (29)

Here the student nurse took exception to the way that a member of the permanent staff was not 'pulling her weight'. It is interesting to note that 'pulling her weight' clearly referred to physical work. The student recognised the care which the nurse in question gave to seriously ill patients, but felt, nevertheless, that the 'hard grind' should be shared by all. The overriding impression of these discussions was, once again, that nursing work is hard and heavy work to be got through. Because of this, students, qualified staff, and auxiliaries alike are expected to join in and 'get through'. If we accept that this is how the work is viewed by the students, a suggestion which is supported by Clarke (1978), it is not surprising that there is an elaborate system of moral pressure and social control in operation in order to ensure that the work is shared. The 'unwritten rules', it could be argued, are unwritten because to voice them or formalise them would necessitate the

open recognition of nursing in these 'workload' terms. Terms which go against the general tide of caring and 'professional' ideals. Students or qualified staff who do not 'pull their weight' and do a 'fair day's work' (Clarke 1978) can be seen to be letting the side down, or not playing fair.

Talking versus working

If such a system of social control is to work, the expectations and sanctions must be clear to those involved. Inspection of the data in this area led to the recognition of the part that talking to patients played in this control. The students often suggested that the permanent staff did not recognise talking with patients as nursing work. The researcher, therefore, followed up the whole topic of talking versus working. The following extract makes the point:

Student: Sometimes people in charge of the ward object, they like you to work all the time, tend to forget that you should go and speak to patients if they see you stand and talk tend to think you are skiving - just not pulling your weight.

K.M.: You used the word work - is talking work as far as you are concerned?

Student: (...) Yes, but just seen as being lazy not pulling weight, you get sent to clean cupboards and things. (10)

There seemed to be several interrelated factors concerned with the 'unwritten rules' of the wards and their enforcement. As it has been said, the main 'unwritten rule' is that the students should 'pull their weight'. According to the students one of the prime indications of their not doing this, as far as the trained staff were concerned, was their talking with patients. Thus, even if there was little work to do it was, generally speaking, more acceptable to try to 'look busy' than to demonstrate lack of work by talking with patients. This argument is

posed rather sharply, and necessarily simplified, in order to make the point. Not all wards operated such a clear cut system of ensuring that students pulled their weight. Some ward sisters, the students said, encouraged them to talk with patients whilst others "allowed" them to. Interestingly the use of the word 'allowed' in this context, whilst indicating a more liberal approach to nursing work, still belies the fact that the students have internalised the idea that physical work is what nursing is about.

The concepts of talking versus working 'looking busy' and social control are, as it has been suggested, interrelated. The following extracts seem to illustrate the point and form the basis of a discussion of occupational socialisation.

One student said that if she got on well with the sister she could feel more relaxed in the ward.

K.M.: Does this affect your relationship with the patients do you think?

Student: I think so, because if you are sort of frightened of the sister you're probably frightened to go up and talk to patients because she'll think you know that you're not getting on with your work. But I think also I found with the younger ones (sisters), who realise that you have to talk to the patients, sort of understand them, and I mean, it might not look very good if a nurse is sort of sitting down by someone's bed, she looks as if she's not doing anything, just sitting having a blether, but I think its very important for the patient rather than just seeing these nurses rushing up and down all the time and not bothering with them. (2)

Another student said:

We are all taught to talk with patients. I've been to wards where you feel you shouldn't talk to patients, its not working, you should be washing walls or cupboards - if you're talking to patients you're skiving not working. (8)

The first extract above demonstrates the ambivalence which the students felt towards talking with patients. They knew at one level that it was a good thing for the patients and, indeed, an essential part of nursing; yet, the rhetoric they used suggested that they had internalised the prevailing dictum of work before talk.

Another student, in describing how a ward sister could show her 'care' for patients, said:

Student: (...) she would go up and talk to patients and tell nurses to go and talk to patients rather than having them looking like they are busy. When I first went into nursing the big thing was for every nurse to look like she was doing something, even if she wasn't, she'd look like she was doing something. I find some other sisters just don't believe that and they want you to talk to patients - one way of showing they care. There's a lot of feedback on those wards.

K.M.: From?

Student: From the students to senior staff.

K.M.: Why do you think that is, because the -

Student: Well, because the students are talking to the patients and getting more information. Probably because on those wards the sisters aren't like - frae the old school they are very friendly (...) one sister will not forbid you but you didn't get to talk to the patients unless you were actually doing something for the patient at the time.* Whereas, on another ward in a quiet spell you could go and sit down and talk to your patient and nothing would be said, in fact, you'd probably be thought of as a valuable member of staff (...) could help in your nursing care. (17)

This student puts forward a practical reason for talking with patients when she mentions feedback. Her rationale for talking with patients is interesting in that she redefines it as a useful part of nursing which can provide information for the senior staff and 'help in the nursing care'. In a sense, she legitimates talking in terms of its function and almost equates it with other forms of nursing work. She then goes so far as to

* Many of these students spoke with a strong Scottish dialect; frae = from.

say that by talking to patients the students can be seen as valuable members of the ward staff, because of the information which they gather whilst talking.

Another student put forward a positive reason for talking with patients when she said that if a student didn't talk with patients it might be suggested in her ward assessment that she lacked confidence. Talking with patients was considered by the students to be a possible sign that they were not pulling their weight and consequently creating a poor impression with the permanent staff. This latter point is of importance to the students as they receive an assessment from each ward which counts towards their professional registration. Thus, apart from the fact that the students' 'day to day life on the wards' was made more comfortable if they discovered and obeyed the 'unwritten rules'; they had good reason to wish to create a favourable impression, namely their ward report.

'Looking busy'

The ward report and the 'looks' given by the permanent staff are not the only means of ensuring that the 'unwritten rules' are obeyed. The other students form a source of social pressure as described by this student. Again, the discussion centred around the key factor, talking with patients.

K.M.: You said you wanted to create a good impression (...) There seems to be a general idea of what a good nurse is.

Student: Uh uh.

K.M.: The image of a bustling efficient nurse who never has time to stop (...) Where do you get that image from? There seem to be things that nurses do which aren't quite sensible, like looking busy all the time, finding things to do.

Student: There is a feeling in the ward that you can't sit down and chat to a patient and no matter if a staff nurse or ward sister says 'Yes go and chat to patients it's all right', you've got this thing inside you that says no, no, I should be going to do this - which is very bad, I don't know where it's from (...) In first year whenever I spoke to a patient I always stood up never sat down, thought sister would think I'm being lazy or something which is ridiculous, if a nurse is always standing up and patient always lying down it hardly puts the patient at ease (...)

K.M.: (...) When you think someone might think you're lazy, you said the ward sister (...) is there any pressure from the other staff, or even your own fellow students - someone has an easy day and I've done all the work feeling.

Student: Yes I suppose there is, if you're sitting chatting to someone and your fellow student goes into the sluice, you keep on thinking I wonder what she is doing, I wonder what she is stocking up or cleaning. You feel you should be helping her with hard work - it's OK if two of you are standing talking but then a patient is not so much at ease with two people - better one to one (...) It is true if your friend is working you should be helping her and not sitting down chatting to a patient. You feel chatting to a patient is not working it's more pleasure. I think that is where the feeling is from (...) Yet each nurse knows that to talk to a patient is very important. (21)

Another student felt that it should not be necessary to 'look busy' when there was nothing to do.

Student: I think they find on the wards that if you've got maybe say half an hour and all the work's done, you know, there's nothing really to do, well most people, nurses in training, they just want to go and talk to patients or something whereas, you know, the sister comes in and she'll make you scrub out the sluices, say, or the treatment room which is a complete waste of time, it's getting scrubbed about ten times a day, you know, and she's just doing that for the sake of, you know, giving you something to do. It's a waste of time sort of speaking to the patients, you know. Things like that, they annoy me. I mean if all the work's done I don't see any harm in doing what you want to do. You know, like talk to the patients and even studying. I mean you get exams and that, I mean when there's not a lot of work to do in the ward there's no reason why you couldn't study but you know they make you either stand about, empty buckets, scrub out the toilets or something. I mean things like that are really wrong. I think, you know, they should make a sort of format, like if for every ward if there's nothing doing, you know, you should be allowed to study or talk to patients instead of trying to

look busy, I mean which is ridiculous because everybody knows that you're just trying to look busy. I mean even when visitors come in they say 'is this you trying to look busy'. Well, I mean they must have some weird ideas about what nurses do, you know. Because when they see you you're always sort of hanging about looking for something to do because at visiting times especially there's not a lot you can do.

K.M.: That's strange because earlier you said the patients tend to think, and I would agree because I've seen it too, think you're always too busy. How do you find that to cope with when, in a way also it is sometimes difficult isn't it when you have got spare time just to go and talk to patients? How do you feel about that?

Student: Most of the time I suppose you are too busy but I think patients conjure up this image that nurses are too busy, you can't interrupt them because I suppose it's just force of habit you're always rushing about and I think there's so much said about nurses and doctors and you know how they're always busy, so much to do and I don't think they realise that, I mean, you know, you're not like that all the time because I mean there's always times that you're not busy and there's not a lot to do. (4)

This student put forward concrete suggestions for legitimate activities which students could indulge in when there is no 'work' to do. She suggests that the 'looking busy' tactic does not even convince the visitors and furthermore it blocks the patients' access to the nurse. On these grounds she favours study time or talking to patients as legitimate activities when the physical nursing work is done.

Discussion

The 'unwritten rules', then, are that the students should 'pull their weight', work quickly and 'look busy' even when there is little or nothing to do. The rules are enforced by the sanctions available, in varying forms, to the work-force on the ward. The ward sister has, as her ultimate sanction, the students' ward reports. The other permanent staff, and indeed the students themselves, resort to group pressures and social controls of a more subtle nature. The following discussion draws

upon literature which is relevant to these data.

Pill (1970) describes the work of nurses on childrens' wards using Goffman's (1958) analyses in 'Presentation of Self in Everyday Life'. Pill applies his suggestion that there are particular aspects of work which are accentuated in the presence of other people and other, less creditable, aspects which are suppressed.

'One of the most popular conceptions about the role of the nurse is that she is continually busy even overworked. This theme cropped up constantly in the interviews at home with the mothers before the child went into hospital, when asked what they thought about unrestricted visiting ... (Mothers) mentioned that the staff had a lot to do and their fear of "being in the way". The latter remark indicates an implicit recognition that the ward is somehow the nurse's territory, a feeling that is certainly shared by the nurses. The mothers are, following Goffman's interesting analysis, "outsiders" trespassing on the nurses' place of work. The introduction of unrestricted visiting means that the nurses are, or likely to be, under observation the whole day by "outsiders"; who will therefore be in a good position to see exactly what and how much the nurses do'. (Stacey et al 1970:118-120)

Pill (in Stacey et al 1970:118-120) found a similar activity to the 'looking busy' tactic described by the students in the present study; she describes this as 'make work'. She also describes the ways in which the nurses achieved the impression of a busy ward.

'The nurse also quite frequently disappears whilst parents are in the ward ... reappearing at intervals to glance round briefly. This fosters the impression of activity'.

In the context of unrestricted visiting, Pill suggested that the nurses found difficulty in determining what behaviour was appropriate in terms of 'on stage behaviour' in the 'front regions' and relaxed behaviour in the 'back regions'. In her words:

'Following Goffman it can be argued that the nurse fosters particular impressions and gives performances to patients, to senior members of nursing staff and to visitors from outside, and that various parts of the ward are socially defined as "back" and "front" regions in various contexts'.

The nurses' behaviour, described by Pill, supports the notion of 'looking busy' developed in the present study. The students appreciated that they engaged in 'front region' behaviour much of the time, yet could not see why 'back region' behaviour could not be carried out in the wards; as instanced by the student who thought that study should be an accepted activity on the ward.

It is interesting to note that one student cited above, felt better about talking to a patient if another student was also talking. She describes an implicit feeling of guilt which is attached to sitting and talking when one student cannot be sure what the other students are doing. This feeling of unease can probably be explained in terms of the student feeling that she might be letting the side down on two possible counts. Firstly, there might actually be some work to do, in which case she is not 'pulling her weight'. Secondly, although there is no actual work to do, the other students may be engaging in the 'looking busy' tactic whilst the student who is talking to the patient is demonstrating, by the very act of talking, that she is not working. Not only is she not working, but she is not prepared to adopt the 'look busy' tactics which support the efficient nurse front dictated by the 'unwritten rules' of the wards.

The social pressures which the students described, from both fellow students and the permanent staff, ensure that the overall pace and 'output' of work remains constant. There is an extensive literature in industrial sociology which describes what has been called 'restriction (1)

(1) Lupton has reservations about the term 'restriction of output' because of its disapproving overtones, but he uses it as it is the term most often applied in the literature.

of output' (Lupton 1963, Roy 1952, 1954). These studies are essentially concerned with reasons behind the gap between expected and actual output from industrial machine shops. The workers indulged in manipulation of the piecework scheme. Roy (1954) concluded that workers behaved as they did in order to protect their economic position. The restrictive behaviour of the workers was aimed at establishing some control over the working situation and earnings. This power struggle is best described by one of Roy's (1954) informants:

'What do you suppose would happen if I turned in \$1.25 an hour on these pump bodies?'

'Turned in? You mean if you actually did the work?'

'I mean if I actually did the work and turned it in!'

'They'd have to pay you, wouldn't they? Isn't that the agreement?'

'Yes, they'd pay me - once! Don't you know that if I turned in \$1.50 an hour on these pump bodies tonight the whole God-damned Methods Department would be down here tomorrow? And they'd re-time this job so quick it would make your head swim! And when they re-timed it they'd cut the price in half and I'd be working for 85 cents an hour instead of \$1.25!'

The general impression given by these studies is that as soon as a worker increases his production the management takes advantage of it, by cutting the piecework rate. It could be argued that the nurses have to appear to be fully occupied throughout their spell of duty, otherwise the administrators responsible for allocation might move them to a busier area of the hospital. So long as talking is not deemed to be working it adds to the time which the nurses 'waste'. The 'looking busy' tactics could, therefore, be compared with the 'time wasting' or 'loafing' which the machine shop workers had to engage in so that they could appear to be

working as fast as the job was 'timed' without actually achieving the required output. The socialisation of new machine shop workers described by Roy (1952, 1954) is similar to the descriptions of the students in the present study. The staff, qualified and unqualified, and other students soon make the newcomer aware of both how much work she must do, and how busy she should appear whilst doing it.

The words which one student used to describe the work-talk dichotomy, namely "work versus pleasure", suggest an extremely puritanical view of what nursing should be like. This conception of talking versus working upholds the idea that nursing is work to be got through, rather than to be enjoyed along the way. The notion that talking is not working is important on two counts. Firstly, the students work under some considerable stress if they feel that the patient wants to talk yet they are equally aware of a strong opposing pull to get the work done. Secondly, if the general ethos on the wards is that talking can only take place once the work is done, the possibility of putting the much vaunted individualised patient care into practice becomes remote.

It is argued here that because of the way in which nursing is construed, namely as work to be done, a tension is produced between the ideal form of nursing and its operationalised form which is practised on the wards. The operationalised form of nursing is hard to fault when it is considered within the context of the busy ward. It does provide an efficient means of 'getting through' and clearly, as these data suggest, the work then talk dictum makes a degree of sense. The student nurse is caught in this tension insofar as she receives the idealised notions about nursing from the college and experiences social pressures on the ward which urge her to nurse in a different way.

The question of occupational socialisation is an interesting one in the case of nursing. The early work concerned with medical students (Merton 1957) took the conventional view of socialisation when the behaviour of the students was seen to be controlled and shaped by the medical faculty, which acted as the agent of the medical profession. The students gradually acquire the professional culture and become fully fledged professionals. Later work by Becker et al (1961) suggested that the students had much more of a part to play in their socialisation and indeed saw the whole process in terms of a negotiation of behaviour between student and professionals. The exponents of this reaction model of occupational socialisation do not consider that the attitudes and behaviour learned during professional education are the major influences on the future behaviour of the students (Simpson 1980). Becker et al focused upon the students rather than the role for which they were being socialised; by doing this they discovered that the students' major preoccupation had to do with short term goals of meeting the requirements of the curriculum rather than longer term goals of achieving professional status.

The reaction approach to socialisation appears to be more fitting to student nurses than the induction approach; moreover it is debatable whether the socialisation of the student nurse can be said to be a professional socialisation or merely a training, 'on the job', which produces functioning nurses. This question is addressed in Chapter 10.

CHAPTER 8

'Nursing in the dark'

This category emerged after a number of interviews during which students described their difficulties concerning what they could say to patients. The students complained that they were often left short of information, or, as some put it, "in the dark", about patients' diagnoses. Moreover, the student nurses frequently did not know how much the patients themselves knew of their conditions; hence the idea of "nursing in the dark" emerged. There is a wealth of nursing literature, particularly in the nursing press, which is devoted to communication with patients. Nurses are being exhorted to talk with patients, to explore their social circumstances, to nurse the whole patient and so on. During these interviews it became apparent that there are very real barriers to this style of nursing inherent in the way nursing is organised on the wards. One factor which appears to militate against student nurses talking freely with patients is the way in which information is handled by the senior staff on the wards. Also, as discussed in Chapter 7, the expectations of the trained staff are such that the students felt that talking was not a legitimate activity, so long as there was physical work to be done.

There is a tendency for the ward report, which students receive at the start of a shift, to be brief and inadequate as a basis for their work. The following students' comments on this issue serve to illustrate the point:

'You know sometimes, on some wards, you don't get a proper report about the patients and you don't feel safe sometimes - not because of your own knowledge but because you don't know what's going on in the ward. It's left to the senior nurses but the ones who have got to do the basic work, the student nurses, are not told properly;

and you don't know what to say to patients when they ask things, just because you are not well enough informed about them. You've got to go and ask this and that one. And you know a patient turns round and says, "I've got cancer" and you say "have you?" or "you haven't", you know, its such that sometimes you don't even know. The ward that I'm in just now, you might not get a report for six or seven days'. (32)

Another student said:

Student: (...) the radiotherapy ward had sixty patients and I think seven doctors, you know, this sister couldn't be expected to come out on to the ward. She'd seven doctors' rounds every morning or something, you know, what else could she do? But she was the type that hoarded the information and just let it leak out slowly to all of us. You know, its very bad on a ward like that (...).

K.M.: How did you actually know what to do?

Student: I had to keep rushing back and forward to senior members of staff - what should I do, what should I say, you know, patients lost a lot of faith.

K.M.: Did you have any sort of patient allocation, or 'those are your patients', 'you do those beds', anything like that?

Student: Yes, she would likely say you work in that room and you'd have six patients and you'd honestly be going round thinking, I wonder what's wrong with this one. You know, cancer of what, and you may be just had six patients but you knew very little about them, only what you could get out of the nursing care plan. And anyway, when you got a report on sixty patients it was, you know, Mrs so and so has such and such, sixty times; you know, I've lost what the first one had anyway.

K.M.: So did you feel that you nursed well on that ward?

Student: Not really that well I don't suppose, I mean your nursing care was good from the point of pressure sores and that kind of thing, you know, but as far as knowledge of the patient and the patient's social circumstances you know, you know very little. You couldn't approach them even if you'd wanted to. It was just like going into cold water, you knew nothing. You know, you just started from scratch. (35)

The above extracts point up not only the main feature, lack of information, but hint at the cause of this state of affairs. The senior nurses have the information yet do not pass it on to those who are in closest contact with the patients, namely the students. The students' lack of information leads, it seems, to further difficulties. When a student does not know all the facts of a patient's case, this, coupled with not knowing how much the patient knows, forces the student into an awkward position. She must cope with the situation by telling the patient something, whilst at the same time preserving her own position, in terms of saving face with the patients.

How much can the student say?

In short, the student suffers from at best, incomplete information and, at worst, absence of information. According to the students, this state of affairs is brought about largely by the way in which information is handled by the senior staff. The over-riding impression was one of student nurses being left in the uncomfortable position of being front line workers with barely enough information to work on.

The students' accounts suggest that they believed that the trained staff were in possession of the information which they lacked. It is, however, conceivable that the trained staff were also "in the dark" in some connections and were merely concealing this fact from the students by seemingly 'hoarding' the information. Alternatively the trained staff might have been employing 'functional uncertainty' (cf. Davis 1960) as a device for maintaining their control over the students. Davis suggested that doctors used clinical 'functional uncertainty' in order

to control their doctor-patient interactions. Doctors, Davis argues, declare their uncertainty of diagnosis whilst still conveying a competence which suggests that their patient management is reliable. It is suggested here that the trained staff might be engaging in a variant of this 'functional uncertainty' as a means of retaining power.

A common problem, aside from not knowing enough about the patient, was that the students often did not know what the patient had been told. Consequently, the students have to develop strategies for coping with this information gap; strategies which often involve evasion and a guarded approach to nursing.

The following extracts illustrate the students' position.

Student: (...) you have to play ignorant, you know, you say 'I'll get someone to speak to you about it', which is really bad because they may have plucked up a lot of courage to tell you. You have to have a staff nurse or a sister come and speak to them about it, you know, it would be good if they had better communication between some senior members of staff, you know, they seem to hoard all the information and nobody gets to know it.

K.M.: Because even if you have to say 'I'll get sister', you could at least appear as if you knew the situation instead of wondering 'what is she going to ask me next?' Does it alter your behaviour towards the patients at all, when you are not sure what they know about their condition or what you can say to them?

Student: Yes, like on the radiotherapy ward, its who knows what, they are always anxious to know what it does (...). The few times they have asked me you can always sort of palm it off, 'I'm not very sure', or 'I can ask sister'. Its amazing the people who don't realise that radiotherapy is a treatment for cancer you know. (35)

Another student said:

Student: (...) there could always be more communication but on the other hand, there are so many reasons why there can't be. I hate to go on about short staffing but sometimes, the time when the patient is actually really needing someone to go and talk to him just happens to be the time when no one has got the time, and later on when somebody has got the time they are not ready to talk about it (...).

K.M.: Have you found that you have been kept in the picture sufficiently with what's going on to be able to tell the patients what they want to know? (...) It has been suggested at some of the earlier interviews that junior nurses have been the ones that have been closest to the patients and the patients will tend to ask them. But often they haven't been told, say, whether a patient knows his diagnosis or whether he has talked to anybody about it. How have you found this?

Student: Well I don't think there is enough, I don't know if any of the students get to know any more, I don't think its just junior nurses, I think it is probably the other students as well. But on the other hand there are some things that they will tell the more senior students but they just sort of brush it off as if to say 'oh you don't need to know about that', with a non-stripe. As you say, it is true that people do ask you more, the junior nurses get asked.

K.M.: And how do you find that to handle?

Student: You do feel ignorant, you do feel that you don't really know enough about this person to really judge it for yourself what you should say.

K.M.: Which seems to be what people are saying, you are short of information anyway just simple things, that the doctor might have said to the patient and you just don't know whether he has or not.

Student: That's right. (1) One patient asked me if he was dying, I said 'Oh, don't be silly, you're doing fine' or something like that. Whereas I had a pretty good idea that he wasn't going to live, I was not absolutely positive and also I wasn't sure whether anybody had spoken to him or anybody had spoken to his relatives, whether anybody had actually said anything concrete or not. Although I think most people would not actually reassure and say 'you are doing fine', not say 'you definitely will live' but 'you are doing fine' or something

1. Note that the researcher had asked for a simple example of information lack.

like that as an easy way out. Because you don't want to take the responsibility on yourself for saying, 'you are going to die tomorrow', or 'you are not going to live'.

K.M.: Especially when you haven't been told anything.

Student: Especially when you haven't been told anything, you don't know where you are. I think that is very important, again I don't think that is just the junior nurses, I think maybe the sister knows maybe the doctor won't have told anybody, you just don't know where you are; or they maybe have spoken to the relatives and told them that they are going to die but have not told the patient, so the patient isn't supposed to know that the relatives know but you don't know who knows. So what if the relatives come up to you and say 'how long do you think he has got?' and you say, 'oh, he is doing fine' but the doctor has told them that he is dying. (...) I think we have to be a team anyway, between medical and nurses and I think if you have come to a conclusion about something everybody should be put in the picture and then also told what is to be done about it, the doctor decides that the patient isn't to be told, then O.K. fair enough that is up to him to decide because it is his responsibility, but lets all of us know what is going on. (...) so you are not only put in embarrassing situations but you might make a mistake. (29)

The first student said that she would "play ignorant" in order to avoid having to answer a patient's question which she was ill-equipped to answer. She felt that, if the senior staff were to keep the juniors more informed and not 'hoard' the information, life might be easier for the student nurses. The second student, quoted above, highlighted the general aura of uncertainty which surrounds the question of talking to patients. The problems which the student nurses face are quite acute, as they constantly encounter patients who may or may not know their diagnoses. Questioning of the students by these patients can be difficult because sometimes the student has no way of knowing whether the patient simply wants to discuss what he already knows or if, indeed, he is seeking information about his diagnosis. It is interesting to note that whilst the students gave the impression that lack of information caused, in the

main, small, irritating, day-to-day problems, when they gave an example it was invariably a dramatic one of diagnosis disclosure. It might be argued that this kind of 'dramatic' event occurs much more frequently in the students' imagination and anticipation of problems rather than in their actual experiences. The stress which comes from "nursing in the dark" is much more likely to stem from the ever present threat of a patient saying 'am I going to die?' rather than from the student actually experiencing its realisation. The researcher gained the impression that the 'does he know?' encounters which the students recalled were very much part of their student 'story-swapping' practice. It is probable therefore that a kind of folklore grows which keeps alive the dramatic side of nurse-patient encounters, yet which bear little resemblance to their daily ward work. (1)

The student nurse's position in the hospital hierarchy has important implications for the ways in which she can handle the situation in which she is placed. She is a junior, unqualified, member of the work-force and as such invariably has to follow specific orders or the general policy of the ward. The students often expressed their own personal views on whether or not patients should be told the truth. They did, on the whole, though, recognise that there had to be an 'official line' to follow; the formulation of this line was generally considered to be the responsibility of the medical staff.

The student quoted above made it quite clear that she was willing to follow the 'official line' but had difficulty in determining what it was because information was hoarded by senior staff. The following extract puts the other side of the coin, although this student concedes that an 'official line' is necessary.

1. I am grateful to Jim McIntosh for this comment.

Student: (...) Most of the patients in my ward have got multiple sclerosis and things like that. There should be a policy where you know where you stand with these people; you can't possibly support them if they know they've got something nasty and they are just waiting for you to tell them they've got something nasty, exactly what it is. Its really weird, they ask you these questions, you've got to be so much on your guard in case you say something.

K.M.: (...) This is something which has been brought up, until now, by more junior students - about them being really on the spot because they are always doing the basic care and the patients will say to them 'what about this?' and they never know whether they are being played off against somebody else, whether they (the patients) really don't know or whether they don't want to hear. And quite often the student doesn't know what to say anyway, because she doesn't know (...)

Student: Well, I've got to the stage where I know if I'm played off against somebody else, usually, unless its my first day on a ward. Just the way the patients phrase things and that, and usually you just try to be truthful. I'm totally against people sort of adopting this sort of optimistic kind of thing, its so characteristic of a lot of nurses, you know, 'you're going to be alright', or 'that wound looks lovely' when the thing looks absolutely revolting, really, I think that's terrible. Any patient with half an I.Q. will see through that. It is possible I think to sort of strike a happy medium with a patient and just listen to him saying very little. You know, they say something like 'I think I might have got cancer' you just say 'oh, yes there is always this possibility but you must wait for the results of your tests'. Whereas they (the nurses she referred to) say 'oh, no, no, you can't have cancer' - that's ridiculous because the patient is bound to feel they are thinking they have got it until they are proved wrong. (32)

This student believed that patients should be given the facts, however, the policy of the consultant was not always to tell the patient and so she felt that she had to follow the official line; this was possible so long as the policy was clear. Although, in general, she said that when possible she tried to be truthful. She felt that it was possible to adopt a "happy medium" approach and usually just listened and said very little. In contrast though, another student said that she had

difficulty in handling situations where she was not allowed to tell a patient about his condition when he asked. She thought that if a patient asked a nurse about his condition, and the nurse knew the diagnosis, she should be able to say something. This rather spirited approach to disclosure was not common among the students. On the whole, they were content to follow the policy of the consultant in charge of the case so that the patient got a story which was, at least, consistent if not accurate.

The following student's comments exemplify this. In discussing talking with patients the question of who should give information arose:

K.M.: (...) Would you say that it is part of the nurse's role, rather than the doctors side of things?

Student: No, I would say it was the doctor's side. Because if a patient is going to be told something its better coming from a doctor or a surgeon rather than a nurse, unless the nurse has been specifically told to tell the patient. It sounds better coming from a doctor than it would do a nurse. (4)

This latter approach points up the implication which the issue has for nursing's claim to 'profession'; this is discussed elsewhere (Chapter 10). It is, however, interesting to note here the acceptance by the students of a subordinate position for nursing, in relation to medicine in the area of communication. This subordination is only one example, among many, of the prevailing medical dominance which, one could argue, prevents nursing from claiming professional status.

Evasion

Even when the students accepted and followed an 'official line' they experienced difficulties in doing so. The students complained that they had to be evasive with patients and, on occasions, "fob them off".

The phrase "fobbing off" was used by the students. The student cited below had some difficulty in describing how she decided what to say to patients and eventually conceded that patients were often "fobbed off".

K.M.: Do you think it helps when you know a bit more about the patient. You often hear younger nurses are frightened that a patient will ask them something that they have not got the answer to (...)

Student: Basically, if a patient asks you something you just, I don't know, I never really think about that. Most people say that they don't know, on the whole, so you ask somebody else and they go, or you say I'll get so and so to speak to you - if you don't know anything. I think basically its still the same and now (i.e. she is a more senior student) you maybe tell the patient what you think they should know. It depends upon what they know already, it depends on what they have, what's wrong with them, how much you tell them, and how much you fob them. Its true you fob people quite a lot in nursing. (...) It is difficult (...) when you know more than they know. Its difficult to cope with.

K.M.: Yes, especially if you do not know how much they know.

Student: And you think they must know something, or more than I think they know. And actually, they are testing you, fishing for extra bits of information. It is difficult to know really unless you have been told directly how much they know you tend to fob them then until you know exactly what they know.

K.M.: And how do you feel when you are doing the fobbing?

Student: Terrible sometimes, but you are told it is not your decision as to how much your patient knows in the situation so you fob them off. But you don't like it because you look at the patient and you think, you are a human being and you are entitled to know because it is your life.

The discussion then moved towards how the information giving could be handled on the wards. More specifically, how up-dating of information should be carried out.

Student: I think the staff should be told at the report, at lunch time - tell you then. I think basically the whole staff should know.

K.M.: Then everybody has the same.

Student: The same grounding to know how to fob the patient off or how to deal with them if they ask you.

K.M.: I was just wondering, you said you felt awful to keep fobbing them off. Do you think that if it was more organised, in that you knew everybody was doing it, that it was the thing to do, would you feel any better about it?

Student: Probably, that you were not the only one that was totally fobbing them off; I mean you knew that they were going to have the same story.

K.M.: Whilst you were fobbing them off was there, possibly, the worry at the back of your mind that you were doing something different anyway?

Student: That somebody is going to come along and tell them something else? Probably, I think so, but you see, I think you would be a lot better if you knew everybody was doing the same. Then it would just seem like a wee white lie, but you're really fobbing them off. (9)

It appears that the students were forced to be evasive with the patients for three main reasons. Firstly, because they often lacked the necessary information, secondly, they did not know how much the patient knew of his condition and thirdly, because they had been instructed not to tell the patients anything. Clearly, the third situation is the least problematic of the three. If a consultant does not wish a patient to be told the diagnosis, then the nursing staff are not in a position to ignore this decision. The question of lack of information is rather more complex. Whether the student is not in possession of the relevant facts, or, does not know how much information the patient has, is a matter of practical as well as analytic interest. The student has the problem of handling the situation in either case; though the tactics used and the difficulties encountered will differ.

The students expressed a fear of telling a patient something which he did not already know. The general confusion about who knew what made this a real problem. The students, especially junior ones, found themselves working closely with patients about whom they sometimes knew very little and still less about the patient's own insight into his condition. If a patient asked a question about his diagnosis, the students were not always in a position to know whether he was 'fishing' for further information, which the medical staff had seen fit to deny him, or, whether he was simply trying to discuss his condition.

This question of 'who knows what' has been described by Glaser and Strauss (1965) in terms of 'awareness contexts'. They discuss the nature of awareness contexts surrounding dying patients, their relatives and the hospital staff. For instance, when the staff and the relatives know that a patient is dying, yet the patient does not know, Glaser and Strauss describe the situation as one of 'closed awareness'. They describe three other types of awareness contexts using the equally self-explanatory labels 'open', 'mutual pretense', and 'suspicion awareness'.

The notion of awareness contexts is applicable to the present study in the interpretation of the students description of information handling. The students were essentially describing what Glaser and Strauss would call a 'closed awareness context'. The difference lying in the fact that this 'closed' aspect could also relate to the students position, vis-a-vis the trained staff. Indeed the students felt that in some cases the patients knew more than they did and were simply looking for additional information or confirmation of what they already knew. 'Suspicion

awareness' might describe such situations. It is not the intention here to fit these data into the categories drawn up by Glaser and Strauss; rather to use their work to highlight the uncertainty which surrounds the whole business of student nurses talking with patients. The uncertainty both of their own knowledge and that of the patient seemed to be the crux of the problem facing the students. The lack of information of which the students complained was not always crucial life and death information. If students are not kept up to date about what a patient knows and does not know about his condition it can make nursing and talking with him a delicate business. Because of the prevailing awareness context a student's construction of a conversation might be very different from the patients. The student quoted above talked about patients 'testing' you and fishing for extra bits of information. The answers which she gives a patient are thus dictated by her perception of his request for information. Just as the patient has little control over the nurse's interpretation of his remarks, so does the nurse have little control over the patient's interpretation of hers. It might be that the student nurses create an impression of conspiracy for the patient when the facts of the matter are that they, quite simply, don't have the answer. Patients may read ominous meanings between the innocent lines of a student's evasive reply to a question. Where there is uncertainty and a lack of facts the chances of misunderstandings occurring are likely to increase. Thus, it could be argued that the uncertainty involved in "nursing in the dark" caused more of the problems for student nurses than did the actual lack of information.

Uncertainty

It is interesting to note here, that whilst uncertainty is seen to complicate the student nurse's life, it has been shown to be of positive use to doctors in their dealings with cancer patients. McIntosh (1977) found that doctors used uncertainty as a means of limiting the degree of disclosure to patients. Davis (1960) introduced the notion of 'functional uncertainty', by which doctors declared their lack of certainty, thus enabling the medical profession to manage and limit its interaction with patients. McIntosh suggested that uncertainty was used in a subtle way in his study, so that it was alluded to rather than openly professed. McIntosh (1977:67) describes how doctors used euphemistic terminology such as 'nasty cells' and 'activity' which does not, in itself, imply uncertainty.

'The use of this sort of terminology also solved a potential dilemma for the doctor: namely how could he use a pretence of uncertainty to restrict information while at the same time conveying to the patient that he knew what he was doing? The method adopted was, as we have seen, to use terms which, while implying uncertainty in sufficient degree to allay patients' fears, also avoided a more explicit profession of it. The doctors could not openly profess to be uncertain about the diagnosis, after having completed their investigations, without the risk of losing the patient's confidence in their ability to treat them. But, the use of terms like "suspicious cells" displayed appropriate combination of uncertainty and confidence in what they were doing to convince the patient that, whilst they might not be certain of the precise nature of their condition, they were sufficiently conversant with it to be able to treat it effectively'.

This extract underscores the subordinate position of nursing, vis-a-vis medicine in the area of communication with patients. The doctor is able to use information and the lack of certainty in its presentation as a means of control of and power over patients. He is able to

function in a comfortable fashion because he is in control of the 'line' that the patient is given. Furthermore, he spends far less time with the patients, and probably exercises a greater degree of control over any interaction with patients than can the student nurse. On the other hand, such 'uncertainty' leaves the patient full of questions which he is very likely to ask the nurse; often the student nurse. In the wake of such a complicated and subtle communication pattern of the medical staff, the student nurse is left with both the patient's received uncertainty from the doctor and her own uncertainty which stems from a lack of information about what has gone before.

McIntosh (1977:71-77) suggests that the nurses were "in a position, had they wished, to bring the doctors' efforts at communication management to nought". In contrast to the students' accounts in this present study, McIntosh found that the nurses were "kept well informed about the patients' diagnosis and treatment"; they were thus potential sources of the information which the patients desired. He does, however, state that:

'Junior nurses had much less experience of what the medical staff told patients, primarily because they often lacked the opportunity to acquire it'.

The nurses, McIntosh found, gave the same reasons as the medical staff for not telling patients, namely, "they believed that patients did not want to know". This statement might, however, beg the question - from where do the nurses take their lead in arriving at this opinion. McIntosh suggests that the nurses "feared that distressed and agitated patients would make life more difficult for them". It might also be further evidence of the dominant position of the medical profession.

The students clearly did not like having to be evasive in their dealings with the patients. The students' position is at once eased and compounded by the fact that they have no control over it. If they are told 'not to tell' then they must not; if they are not given information, their position is such that it is difficult to obtain. Yet they are placed in a position of having to do something when the patient asks his question. The fact that the students' position is not one which they adopt voluntarily does not make the evasion and the "fobbing off" any easier to come to terms with.

One student, who admitted to answering questions in as vague a way as possible, seemed to take refuge in the fact that she had no choice about being evasive with the patients. Her description of answering patients' questions was unique among the students interviewed. It is cited here in order to throw the main argument of this chapter into relief. The majority of the students expressed concern about the restrictions placed on their talking with patients. This student had a rather different attitude:

K.M.: How do you feel about the nurse's role in giving information, how have you found it?

Student: Well, at the moment I try to be as vague as possible and pass it on to the sister (...) I try to be as vague as possible you know, put it down in as broad terms as possible. Well, if they have an obstruction, well they want to know what an obstruction is, you just tell them it's something that's clogging their insides up. And if they ask what is it - what is clogging my insides up - just say - could be anything from constipation - millions of things can clog you up. And I have found in my experience so far that that more or less satisfies them, knowing that you can't boil it down to one particular thing or if there are still tests being run on them - just say 'I don't know, we haven't got the results of the tests'. Then tell ward sister or whoever is in charge at that time - that they have been asking - and what I have said so that they are in the

picture in case somebody else gets asked and that it slips out. You know - it keeps you in the clear because as sure as fate they're bound to come up and say who else has been asked. It keeps you in the clear but at the moment I try to be as vague as possible and pass it on to the ward sister. (4)

This student, apart from seeming to be content with evasion and vague explanations, made a practice of telling the ward sister what she had said in order to "keep in the clear". This style of handling the patient's question, whilst not typical, did seem to offer a solution to the problem of truthful communication. Indeed, viewed in this way the problem did not exist.

Not all students were prepared to be evasive. There was, even so, a reluctance to admit to complete ignorance when a patient asked a question.

Student: If I don't know then I'll tell them I don't know the answer and I'll find out for them rather than fob them off with something.

K.M.: And have you always been like that, when you were a junior and you really didn't know, or probably knew a lot less about things and it happened to you more often?

Student: I think then rather than just say you didn't know directly, say you weren't very sure.

K.M.: I've often wondered if there is something in nurses that they are always supposed to do everything, the public see them as, well I don't know what they see them as, but they can cope with any situation and you are rather taught a little bit that way, I just wonder how, when a patient asks something, is it easy for a nurse to say 'I don't know'.

Student: No, because, well it depends on what they ask you, but they tend to look at you as if you are stupid if you don't know the answer. I think it is better to say 'I'm not really very sure', than spin a yarn of what you think it might be, then find out. (10)

Another student:

K.M.: Do you find that you have to kind of hedge your bets sometimes if you don't know what the medical staff have told them?

Student: Mm, you have got to kind of, you ...

K.M.: How do you deal with that?

Student: You go round about it in a very non-committal way, I think you just try and make your patient feel that you have answered the question, you know, saying that you will check and try and get the doctor to speak to them as well. Tell them something that's going on, if you can (...) you feel pretty useless if you really don't know. Once or twice I've had to say 'I'm sorry, I just really don't know what's going on but I'll find out for you'. You feel that you are lacking. (18)

It appears from the above extracts that, alongside the strategies for coping with nursing on the basis of scanty information, the students had to find ways of 'face saving' when they were in awkward situations. Student nurses seem to find difficulty in admitting when they do not know something. The ideal image of a nurse, who can cope, knows all the answers and is always efficient, is, in some way, seen as a goal to strive for.

Clearly, if students are often deprived of the necessary information required to function in the front line, and, furthermore, do not like to admit when they don't know, there are times when student nurses find the work very stressful. Student nurses are exposed to the worst side of life at quite a young age, and have to cope the best way they can (cf. Menzies 1960). As it has been argued, the students felt that there was a move away from the patients as they become more senior. This leaves the junior students, to a greater extent, in the front line. These students are least well equipped to cope, by virtue of being short of confidence and experience, less knowledgeable than their seniors and, for the most part, the youngest nurses on the ward. Also, the junior students do not have the status, nor the permanence, which would help them to function in this front line position. Without trying to explain

their position in too deterministic a way, it does seem that, because a student is seen to be a junior, and one who is just passing through the ward, she cannot hope to carry off her duties in the same style that a senior student or staff nurse might. Nevertheless, patients do commonly turn to the junior nurses because they are the members of the nursing staff that the patients encounter most frequently. McIntosh (1977:76) found the opinion of the junior nurses divided upon the issue of which sector of the nursing staff was questioned most often. Some thought that the constant presence of the juniors encouraged questions, others that patients would not ask juniors, as they did not like to upset them.

The following extract seeks to illustrate some of the points of the above discussion.

K.M.: How do you find talking with patients, do you find it easy?

Student: At first I found it very difficult, but I think that was because I was very shy and hadn't had much experience so obviously as I've got more into nursing and I've become more confident, more able to talk freely, also as I've become more senior, it gives you a feeling of confidence when you are talking to them (...) felt very junior and very inferior, which I don't feel so much now I feel more on an equal basis, with anybody.

K.M.: How do you feel about information giving?

Student: That's quite important especially nowadays. I was quite surprised at how much patients knew about their condition (...) Patients do ask you a lot and they do ask you awkward questions.

K.M.: How do you find that you always know what the medical staff told patients or are?

Student: You are sometimes left in the lurch (...)

K.M.: How do you deal with it if you are in the lurch, as you say, because you never know?

Student: I'd refer it to somebody senior to myself (laughs)

K.M.: Which is presumably no bad thing, because you could be in a position where a patient is asking you to say something that he hasn't yet been told, whose responsibility is that (...)?

Student: I would never tell a patient something that I didn't think that the doctor hadn't already told him, I would refer it to someone more senior, e.g. charge nurse, because it is the medical staff's responsibility and if they pass it over to the nursing staff then it's the nurse in charge of the ward's responsibility. Because right now I don't feel that I'm capable of telling somebody that they have cancer or that a relative has passed on. I don't know how I'm going to take to that because I almost got left with it once and it is very frightening because I wouldn't have known what to say.

K.M.: (...) in a few months time when you are a staff nurse and you do get landed with this (...)

Student: I don't know how I'm going to react, I suppose I'll jump that bridge when I come to it. (17)

This student felt subordinated as a junior nurse. As a second year student now she cannot envisage telling any patient that he has, say, cancer. When asked how she felt that she would cope when she became a staff nurse and had to do these things, she said that she "would jump that bridge when I come to it". This, rather flippant, answer is, of course, nearer to the truth than many might care to admit. The question of anticipatory socialisation is discussed elsewhere (Chapter 7) but comments such as the one above serve to emphasise the point that this type of socialisation is not prevalent in nursing.

Establishing a 'professional' relationship

How, then, does the junior nurse learn to handle her role? This chapter has been concerned with the students' description of talking with patients. It is appropriate, therefore, to examine the question of acquisition of the skills and behaviour expected of qualified staff, with reference to establishing a 'professional' relationship with the patient.

A number of the students said that they watched senior staff at work and copied their approaches to the patients. This was not always considered to be enough, as evidenced by the student quoted below.

Student: Well, I don't think we get enough in our training, enough sort of formal education on how to speak to folk. We get psychology lectures but nothing really on how to just sit down and speak to somebody. The other day I was put in a situation when a patient was dying and nobody expected her to die, sort of thing. As soon as she did, and at the time there were six of her relations round the bed when she sort of took her last breath, and they all broke down, and everything ... And I sort of suddenly realised I was in that situation and I thought 'oh heck - what do I do now?' I ushered them off and made them a cup of tea and asked if there was anything I could do - and ... Even if you did have formal education in how to speak to folk, I don't think you can until you have come up against it. (34)

The example given by the student quoted above is a rather 'dramatic' one yet serves to illustrate the position in which the students find themselves. She made the point that little formal instruction is given which might help the students in these situations, but went on to say that she doubted the utility of such instruction in any case. It seemed that, whilst the students would like some guidance and reassurance as to the efficacy of their actions, they are mostly resigned to the 'baptism by fire' which they experience. The student still has the problem of a lack of qualified nurse status when she is being asked to carry out work which, it could be argued, is more properly the concern of the trained staff. The data allow no more than a few discursive remarks. The researcher suggested to the student, quoted below, that the students were in a difficult position when it came to establishing a 'professional' relationship with patients. They are seen by the patients as students and, as such, might not be viewed in the same light as, say, the sister

or staff nurse might be. This led on to a discussion of how the relationship is founded.

Student: (...) You have to show that you are a friend to them, that you are willing to be a friend first and that they can rely on you to help them, to show that you are interested in them as people.

K.M.: How do you find that, it was interesting that you used the word friend, is there any difference between that and the professional image of the nurse? I'm interested in just how you go about making a relationship with people.

Student: Well of course you still have to have a professional attitude but on the other hand I don't think anybody wants to be seen as a starchy person, they want to see that you are human but that you are capable of doing certain things in a professional manner. That they can depend on you to give them the right help that they need but without being a complete alien special kind of person, that you can't communicate with.

K.M.: So would you say a friendly professional?

Student: Yes.

K.M.: I wondered too a little bit about how you manage to develop that as a junior nurse, how do you go about it because you are at a bit of a disadvantage if the patient is going to think 'she has only just started'.

Student: Well, I think it is also an advantage in a way, I think that it is easier for the junior to show that you're accessible as a person because the patients are not really expecting you to do anything terribly technical or anything right from the first word. Also you are nervous too and you want to make friends, you know, have a friendly basis with people, you don't want to be scowling and hiding and thinking everyone is thinking you are a fool for not knowing something. I find it quite easy to talk to people anyway and I'm usually quite cheery on a ward. I think if they see you singing or something like that, smiling or joking they think 'oh what a nice friendly type of girl' and that brings down the doubts that you might have that you might be a sadist or something (...). I think it is just your general attitude on the ward and your way of speaking to the other nurses as well and also how they treat you - I think gives them an idea of what type of person you are (...) (29)

'Professional', was the word used by the students in order to describe the nature of the relationship with the patients, which they felt was appropriate. There seemed to be two main opinions expressed by the students in relation to the ease with which students could establish a relationship with the patient. One school argues that, the student can only try out her qualified nurse role, and its appropriate behaviour when she is a qualified nurse. The other maintains that the junior student is closer to the patient and can, therefore, develop a friendly relationship with patients, who, in turn, will not expect too much of her, precisely because of her junior position. A further complication exists for the student who wishes to copy the behaviour of senior staff. This lies in the fact that role-modelling, it could be argued, has its limitations insofar as when a ward sister or staff nurse speaks to a patient or answers his questions, she does so from a particular status position which the patient recognises. The patient sees this as her province, to make a crude analogy just as he might expect his bedpan from the junior student, so he expects his information from the qualified staff. In some ways, therefore, it matters less how the information is passed but by whom it is passed. This fact makes it difficult for the student to learn these skills as she can only really get it right when she has the necessary accompanying status.

Discussion

The students, on the whole, expressed a willingness to talk with patients. Indeed, in some cases one might argue that they were almost over eager to discuss delicate issues with patients. There seems to be a tension between the students' belief that a patient has a right to know

and their lack of ability to talk openly with patients. This tension is resolved by the students' accepting that the doctor has responsibility for determining what his patient should know. Also, in practice, the students were often either kept "in the dark" or told "not to tell"; in this way their desire to give the patients the truth was curbed if not resolved.

This category raises important issues concerning how far the student nurses should be treated as members of the ward staff. It seems that they are expected to function as full members of the work-force yet they do not have either the experience nor are they given the responsibility to go with it. The student is in a permanent dilemma as a front line worker. She is taught in college that to talk with patients is an important part of care; yet on the ward this is made difficult if not impossible because of the way in which the information is handled by the senior staff.

CHAPTER 9

'Just passing through'

This category emerged from a consideration of the students' descriptions of the constant movement, from place to place, which occurs throughout their training. From the start of training most of the encounters which the student has are circumscribed by place and time and are, invariably, short-lived. The placements in various hospital wards and departments, spells of experience in hospitals, other than the main training hospital and periods of time in the community are all arranged around blocks of weeks spent in the college of nursing. This fragmentation of the three years means, in effect, that a student moves on average, every eight or ten weeks. Thus, one of the main features of the student's life is transience.

The notion of transience came to the researcher's attention first of all, in the consideration of the data concerned with the students' adjustment to the different expectations of the ward sisters. In the course of the interviews, the students made few specific references to the fact of their moving from place to place, possibly because this aspect of their lives was taken for granted by them. Nevertheless, there were many indirect references to their ephemeral student life. Phrases such as "just passing through" were used by the students in describing the transient nature of their interactions and the attendant consequences. It was, therefore, coined as the descriptive label for the conceptual category, 'transiency', which is elaborated in this chapter.

There are many aspects of the general notion of transiency in relation to the life of a student nurse. A number of these are addressed here. Broadly, it can be said that the fact of the transient nature of the students' encounters leads to several

consequences for the students themselves, the permanent staff and, necessarily, the social organisation of nursing on the wards. It is contended here that the students utilise transience in order to 'get through' their training. It allows them to escape long term responsibility for their actions because of their status as a moving population of workers, with some claim to student status. This same factor, it is argued, allows trained staff to justify their behaviour towards the students in terms of delegation of authority and responsibility. The questions of the students' rationalisation and the staffs' justification of the organisation of the student experience form the major part of the discussion of the category, "just passing through". Finally, the transition from student to qualified nurse is considered in the context of the extension of transiency into the post-registration phase.

The following extract touches upon many issues and in so doing provides an overview of the problems of transiency.

This student wanted to move on to another hospital in order to see different ways of nursing.

Student: I'm (name) Hospital orientated and to me there is no other 'right' way of doing a bedbath, or right way of doing this; and I'd like to see other ways.

K.M.: Do you find that there are routines that are hospital wide, does it feel like a hospital or a collection of wards?

Student: Well, like certain procedures you have a procedure manual and every ward does it exactly the same way.

K.M.: What kind of things differ from ward to ward?

Student: Bedbathing obviously differs.

K.M.: What, when you do it, or how?

Student: When and how you do it. Talking to your patients differs in different wards (...) the sister sets her guidelines, its her ward, her domain and you do not interfere.

K.M.: Do you feel as a moving student population through the wards? Do you feel an outsider?

Student: You do feel an outsider, my staff (i.e. the staff on her present ward) make you feel like that.

K.M.: What about working with auxiliaries, are they nearer to you or staff?

Student: They are nearer to senior staff, because they are there all the time (...). Auxiliary nurses should be changed from ward to ward, if they get into a (...) niche with the sister on the ward. If you take a dislike to an auxiliary or they take a dislike to you they can make your life misery because they take back to the senior staff - they come back to you(...) I would move them around if I had my own way. I think sisters should move, I wouldn't allow them to get into their own sort of rut. I think if you moved a surgical sister to a medical department, she wouldn't have a clue, and that is wrong because you are obviously getting out of contact with one aspect of nursing and just sort of staying in your own wee cupboard.

K.M.: Do you not think that it is a bit inevitable?

Student: I don't see why it can't be changed. I don't see why they can't be rotated on a two yearly basis or something. Giving them long enough to get into a ward, to put in her ideas, her way of thinking and then changing her. Also it would work in a profitable way for students (...) (17)

The student quoted above appeared to have accepted the transient nature of her work. Indeed, she implied that transiency was conducive to good nursing practice and advocated that it should be extended to all nursing staff, in particular to ward sisters and auxiliaries. This is not an uncommon practice; for example it is often found in military settings.

'Getting on' and 'getting through'

There are two other main points to be drawn from the extract. Firstly, the nature of the relationship established between the student and permanent staff on the ward seemed to be an important factor in determining whether a student enjoyed her period of time on any particular ward. Secondly, that the students were aware of having to 'fit in' with the 'ways of the ward'. Most of the students described this need to adapt their behaviour as they moved from one ward to the next, in order to meet the expectations of the sister and the permanent ward staff. The following extract illustrates the point.

K.M.: How do you find that you get on with the trained staff, as a student moving around every ten weeks (...)?

Student: As a new student on the ward you get really depressed because, I think, even before you begin to think about the patients and how you are going to treat the patients you begin to think - 'just as long as I settle into the ward, get on with the staff'. That's the most important thing. You become very two-faced you know, really, you're doing some things and doing other things just to get on with the staff; and once you've been accepted by them, then you begin to think more about the wards and the patient care and everything else. But, its horrible, if you are in an atmosphere where you're not liked, you're not wanted; and when you first go to a ward you feel that anyway. (35)

This student exemplified the feelings of many insofar as her first priority on going to a new ward was not patient oriented. The students' attention, it seemed, was focused initially upon the permanent staff. They felt that it was important to get along with the trained members of staff and the auxiliaries, as well as with the ward sister. Thus, the constant movement from ward to ward, it seems called for the students to develop a means of coping with and functioning within the system.

From their descriptions of these coping strategies, the researcher developed the notion of transiency as an explanatory category, which allows some insight into the students' perception of "just passing through" a collection of hospital wards.

Transiency has advantageous and disadvantageous consequences for both students and permanent staff, these are addressed below.

Transience as utility

One of the notable features of the students' accounts was that 'transiency' was, on the whole, accepted as a fact of a student nurse's life. This acceptance can be explained, to an extent, by the very nature of transiency. The students, it seemed, were willing to cope with anything during their training because it cannot last longer than eight to ten weeks. The students' accounts suggest that however bad things were, and however much they disliked the work they were currently doing, the fact that it would only last a foreseeable amount of time made it bearable. The length of each ward experience was, however, important. The students needed to be in one place long enough to establish what the expectations of the permanent staff were, to get to know the ward and its routines and then, these priorities being achieved, to get to know the patients. As the student, quoted below, put it.

K.M.: How do you find that as a way of learning to become a nurse, moving every eight weeks or so?

Student: As long as you are there for at least six weeks in a ward, its not so bad, but if you are only there two weeks you haven't got time to get to know your patients or your staff, you're really a waste of time on the ward. You don't know what your patients wants, don't even know if they are supposed to get up. By time two weeks up (...) you have got to learn to work with other people when you

go to another hospital, when you are through your training you have to adapt again. You adapt all the way through your training.

The same student went on to describe how important her relationships with the permanent staff were.

K.M.: Do the permanent staff have anything to do with whether you enjoy a place or not?

Student: Yes, I think they do, an awful lot. I've had no problems, but I know some of the students haven't been able to give and take. You have got to be able to give and take or you won't get anywhere in nursing. Just got to go as the wood goes.

K.M.: Is there an 'us and them' feeling if the students are moving through every so many weeks and there is a permanent force sitting there waiting for the next lot - do you feel?

Student: Yes in some places, yes this does happen. This is why I feel you should have a rotation, sisters throughout the block (in group of wards).

K.M.: Do the trained staff stay quite long?

Student: Yes, you have normally got, maybe two sisters, a staff nurse, two enrolled nurses and your auxiliaries are all permanent. Your students are the only ones who are floating through (...) Staff nurses do change quite frequently, but your auxiliaries and enrolled nurses are in with the bricks.

K.M.: So is it more them that you have to get along with, in some cases, than the sister?

Student: Yes, in a lot of cases its the auxiliary and enrolled nurse. (...) auxiliaries will come and tell you in here we do it this way, this is the way its done. If there was a rotation the auxiliary who has been in the ward for maybe five years, would see that it is done differently on other places.

K.M.: And people still live?

Student: People still survive, yes you know (...) (laughs). Important things - there are at least one or two really permanent staff stay - they know how the doctors work. Maybe even six monthly.

K.M.: Is it unsettling having to go from one ward to another, or do you like the variety?

Student: It's unsettling, it takes you about a fortnight to get into the routine of a new ward, you worry for about a fortnight before it.

K.M.: (...) it's almost like going to a new job every so many weeks?

Student: Yes (...) when I know which ward I'm going to next, I go round everybody I know that's been to that ward, and find out as much as I can about it. And start worrying. Then the first week I hide away (...)

K.M.: Can you say who you do pick things up from ...?

Student: I follow the auxiliaries, because they have been there for years, know how the sister likes it done. Tend to follow them or the enrolled nurse. I've even asked domestics, because they are permanent as well, they know when sister likes her beds moved, this sort of thing. (26)

This student advocated a rotation of staff around the wards, in other words, that transience should be built into the system of staff allocation. This rather unusual point of view helps to clarify, albeit in an extreme way, the students' perspective on nursing, namely, a constantly changing scene. This student also felt, though, that moving around the wards was an upsetting experience. It could be that the length of stay in a ward is an important feature of transiency; a feature which makes the prevailing form of student work organisation acceptable. There is, however, as she concedes, a need for some permanency. Clearly, if the main nursing work-force is to be rotated through the wards, either the style of running the wards would need to change or, some members of staff would need to remain in one place in order to initiate the itinerants in the ways of the ward. At the present, this student's account suggests that the long-standing stable element of the nursing work-force comprises, in the main, the nursing

auxiliaries. The role of the auxiliary in the socialisation of the student nurse was frequently mentioned by the students. The quotation below accurately reflects the students' experiences with this unqualified sector of the nursing work-force.

Student: They (auxiliaries) have so much got into the way of doing things, that they do it a certain way and you have just got to fit in with them. That is very much so on night duty. There is no way you are going to change their routine on night duty; you just have to play along with it. You are only there for six weeks, there is not much point in stirring things up.

K.M.: The sorts of things that you have to play along with; are they things that are really rather minor, or things that actually matter?

Student: Usually very minor, for example, the ones (auxiliaries) on night duty, they are really rather good. If ever you needed anybody to use their commonsense, you couldn't be better off. But it's just a bit annoying feeling that you are supposed to be in charge but you are no more in charge than fly in the air. You have the responsibility, but they just do things the way they've been doing for years. To begin with you have to rely on them, it's quite comforting at that point, it's only when you get into the way of things. (8)

As it has been discussed in Chapter 5, the students were, on the whole, prepared to accept the dominant position of the auxiliaries in the running of the wards. They freely admitted that the auxiliaries were of help to them both in getting to know the ward and in discovering how 'things are done here'. Also, as evidenced by the comments of the student quoted above, there was a certain amount of resigned acceptance of the status quo; "there is no way you are going to change their routine". In a situation where the student nurse has to subordinate her knowledge and position, such that it is, to a favoured routine of an unqualified member of the permanent staff, some means of rationalisation is required by the student. Transiency is utilised in such a situation; the student can fall back on the fact that she is

"just passing through". As the student quoted above said "you are only here for six weeks, there is not much point in stirring things up". Indeed, bearing in mind the suspected collusion between auxiliaries and the ward sisters, the students seemed to be wary of adverse comment entering their ward reports via the auxiliary. This has been discussed in Chapter 7.

The auxiliaries' usefulness to the students in terms of 'on the job' teachers and a means of keeping the students 'on the right side of sister' have also been discussed in Chapter 7. The argument is re-stated here in the context of 'transiency' in order to illustrate one of the ways by which the students rationalised the transient nature of their student nurse experience. That is to say, the students were able to recognise the disadvantages of transiency, yet, rationalise its place in the training programme. The constant movement was generally accepted and rationalised by the students on the grounds that moving around gave them experience, not only of different specialties, but of different ways of organising and practising nursing. As one student put it "I suppose it gives you a variety of ways of how to do different things".

Students as a labour pool

One of the most important consequence of transiency seemed to be that the students form a mobile labour pool. Student nurses are seen as the first people to move if extra staff are required anywhere in the hospital. The students learn to adjust, fairly quickly, to the planned moves which constitute their rotation through the wards during their three years training. Advantage of this ability to adapt is taken by the nursing managers, who are responsible for day to day staffing levels.

The students are used as relief nurses, or as they put it "extra pairs of hands", at very short notice. Thus, the notion of transiency becomes relevant, in that there can be said to be 'moves within moves'. The students cannot be sure that they will be kept on the same ward, even during the span of one shift.

The following extract illustrates the point.

K.M.: What do you think about it as a system of training people when you look at it in those terms; you are moved around, yes, to get a look at the different things that are going on, but you're constantly breaking new ground.

Student: Oh this is a good one (laughs) what I think of the system. I think it's a very good training and you learn so much, but, I really think that they use you as students. Well, for instance, this morning I went on at 7.30 and started cleaning in casualty, and there is a lot of cleaning to be done, so I did all that work there. At 8.30 I was moved to a heavy ward to help with bedbaths and bed making, that is quite strenuous. Then at 9.00 I had to go back and start all the dressings in casualty, because it is busy there. Well, its not common, but you find you are being used to help with the heavy work and well, its just annoying at times, and you wonder if people do appreciate you, or whether they just think, oh, this is a student we will move her from here. (21)

This student, having recognised that it is a "good training", went on to say that she felt used. As she explained, student nurses could end up working a very 'heavy' day as they were invariably moved to another ward in order to help out over a busy period, having just worked through a busy period in their own ward. In this way the student did not experience the peaks and troughs of an average shift but was forced to work on an atypical shift between wards, and, more to the point, a shift which comprised mostly peaks.

The use of the student nurses for short term relief in low staffed areas of the hospital was described by the students in terms of their 'being used', or even abused. It seemed that the students felt that the

nurse managers viewed them as pairs of hands to be moved around the hospital at will. This phenomenon went beyond short term relief during one shift. The following extract shows how, once the students were nearing qualification, their potential as useful mobile labour was still tapped.

Student: When you sit your finals you are supposed to have three choices of where you would like to go for your pre-registration. I said I would like to go to the recovery for instance and somebody said 'you'll never get recovery room' and I said, 'well, why not - that's where I'd like to go'. All your training you are pushed where you are needed as an extra pair of hands, trying to combine your clinical experience in between and oh well, they couldn't put a third year student - 'waste of a third year student in the recovery room' I thought - how is it a waste, that's what I'd like to do and I think I would like to do that kind of work for a while - How is it a waste, you're supposed to get a choice but in fact if you're lucky enough to choose a heavy ward, to have really liked heavy wards you'll get it sort of thing. There's no question about it and if you asked for anything else you would probably not get it you know, and that's really terrible.

K.M.: So this is the time where you're supposed to have a chance to begin to learn how to run a ward and the management part of it?

Student: Yes, yes, and apart from that, places you might be interested, you know, in going to (i.e. after qualified). If its some place heavy you choose, you would probably get it, its a waste you see if its of benefit to you. From a nursing management point of view, its a waste, an extra pair of hands in the recovery room because you are only looking after one patient, one ventilator at the most. 'Come to another ward some place else, must use this girl while we've got her'. (32)

The above extract illustrates the students' view of how they are 'used' by nursing management. The students constitute a mobile labour pool, experienced in moving around and fitting in on different wards. As they become more senior, their existence is even more useful to those responsible for staff allocation. The students often expressed the idea that a third year student is seen, by the management, as a useful entity.

Useful, insofar as she can be expected to take on a certain amount of responsibility or at least adapt to new work situations with little difficulty.

This point was further underlined when one student described the practice of "making up lost time". If a student is off sick during a spell of required experience, she is expected to 'make up time' in order that her training record can be signed to the effect that the required number of hours have been spent gaining different nursing experience. It seemed that this ruling was upheld when the students were off sick, but not when they missed experience due to being moved to 'help out' elsewhere.

Student: And another thing that really aggrieved me - we went to do our paediatrics - a two month secondment. If you take more than three days off for something, you're sick, something like that, you've got to make up a week in paediatrics again because you've lost a week of experience. On the other hand, I spent most of my time in paediatrics helping out on the medical and geriatric wards - days here and there was that not also losing paediatric experience?

K.M.: Yes.

Student: You're supposed to be here but you can be used for any ward 'kids are very quiet', you know. And fair enough, I think it's terrible that there are some wards with no staff and that that's because trained staff don't want to work there. There's some wards that never keep trained staff or auxiliaries because nobody wants to work there and that's it - it's just terrible. You end up going there and yet you didn't lose out in that way; but if you took three days off, back you'd have to come. And that was much more than three days off in geriatric wards. (32)

One of the major consequences of the transiency which characterises the life of the student nurse is then, this feeling experienced by the students, of 'being used'. They felt used as a reserve supply of nurses for short term relief or for placement in unpopular areas of the hospital.

This abuse of the rules on loss of experience is an important point. The students mentioned it in a resigned accepting way which belies the importance of the issue. Throughout the interviews the researcher had the impression that there was a lot of goodwill and positive motivation towards their work among the students, which, it seemed, was difficult to dampen. In their accounts the students expressed feelings of being 'used' and this question of 'making up time' is an important example of this. It could be argued that such an issue would be taken up in a militant sense if a similar practice were taking place in other areas of higher education. The students seemed to accept these 'abuses' of their position in a passive way possibly so that they did not damage their chances of achieving registration. They concentrated on 'getting through'.

Organisational slots and stereotyped students

The students' descriptions of the attitudes of the permanent staff, in the context of a discussion of transiency, are also illuminating. The attitudes of the trained staff towards the students, it is argued, are, to an extent, affected by the fact that the majority of the nursing work-force is made up of this transient student population. The permanent staff on the wards have only a short space of time in which to get to know and assess the students who pass through their ward. The staff are unable to get to know the capabilities of each individual student on a personal basis and thus, they tend to deal in stereotypes. Each ward has a number of slots labelled 'student' and individual student nurses come and go through these empty positions. Thus, each student is judged on the basis of being a first, second or third year, and according to a generalised notion of progress through training is expected to be

able to do certain things, contingent upon her seniority. Strong and Davis' (1977) discussion of role formats is helpful here. They, in describing the decline in usage of role concepts say that the concept of role "provides a link between observable behaviour and more abstract structural concerns". Strong and Davis draw on Goffman's work, who, they say, rejects the "deterministic notion of interaction on which traditional role theory was based". They go on to say that, in Goffman's terms:

'the ceremonial order is based on a "working consensus" as to what the nature of social reality is to be for the present purposes, at least overtly'.

Strong and Davis take this argument further in a search for more general social orders, they offer 'role formats' as a concept which encompasses both the stability in relationships and the variability which 'role' itself does not allow.

'If the norms within encounters are generated by a particular balance of resources among the participants then, where the conditions are such that this particular balance holds true across a broad range of encounters a routinised solution is liable to emerge. Its use avoids uncertainty, cuts out initial skirmishings, avoids trouble and enables a rapid concentration on the task at hand'. (Strong and Davis 1977)

Strong and Davis use their concept of role formats in a discussion of professional-client encounters in a medical setting. In describing role formats, they emphasise their flexibility and nature as technical solutions to interactional problems. In the context of the present study the notion of organisational slots on each ward, which awaited the permanent staffs' stereotyped version of students is analytically similar. The students' behaviour can be conceived of along the lines of role format usage resulting in the production of routinised and relatively stable responses

from the variety of students on the wards.

The following student's comments make the point.

Student: Yes you certainly feel that you ought to have done, say, so many catheterizations by the time you become a red stripe (i.e. third year student), because you will be sent off to do them by yourself. If you never managed to get in on the action before your third year (...) you feel a bit of a fool to have to say actually I've never done one before, its never cropped up, which does happen. (...) or just read up your little blue nursing procedure book and you bash on regardless which does happen, I'm sure.

K.M.: I wonder if there is an expectation that you should be able to do this, and you try to live up to it, by doing it, without asking.

Student: I think that does happen actually.

K.M.: The feeling that you can't say I don't know?

Student: Yes, I think it becomes more pronounced when you're a third year. One time I had to go and take out clips which I hadn't done before, as opposed to stitches which I'd taken out millions of, and I felt such a fool having to admit 'well actually I've never seen this'. (33)

This student expressed the thoughts of many of those interviewed when she suggested that it becomes difficult, with seniority, to admit a lack of knowledge. It seems that the 'stereotype' conceptualisation of the student nurse becomes something of a reality for the students themselves. They find themselves in a system which assumes that a third year student is capable of x, y and z, and thus have a desire to be able to fulfil that expectation. Moreover, the students admitted to feeling a certain amount of guilt if they could not meet the expectations of the stereotype appropriate to their position in the student nurse ranks.

The notion of students 'passing through' and the use of the stereotype by the permanent staff, as a means of handling the situation, led to the idea of the interchangeability of students in the eyes of the

trained staff. That is to say, students are not seen as individual nurses, but rather as a student, with certain capabilities, from a pool of similar students. The permanent staff might have Nurse Black this week and Nurse White instead next. So long as Nurse Black and Nurse White are both, say, second years and can function at the required level it matters little that Nurse White is not Nurse Black. The students' views on their treatment by the permanent staff seemed to be mixed. As it has been suggested earlier, the transient nature of the student life is rationalised by the student. The students appear to accept most of what comes their way, with varying degrees of good grace as part and parcel of the student nurse training programme. Thus, it seemed, that they were reluctant to openly criticise the college or the wards and, in order to make their position tenable, they would rationalise their treatment with a sense of che sara sara. The students were also prepared to justify, on behalf of the trained staff, the attitude of the trained staff towards students. This justification is based on the essence and consequences of transiency, in relation to the student role. As one student put it:

'it must be very irritating for trained people as well.
A new student to get into the way of things every eight
to ten weeks, but at the same time, they forget you are
another individual person'. (35)

This student exemplifies the views of those interviewed who, whilst not liking the trained staffs' attitudes towards students, could see that from the staff's standpoint it was an understandable one and thus justified it on those grounds. We shall return to this theme later.

Settling down

The discussion of transiency and the experience of moving from ward to ward led, naturally, to the question of eventually settling down. There were varying opinions among the students concerning the desirability of staying on each ward for relatively short periods of time. The longest spell was on their first ward, where the students spent thirteen weeks; after that an average period of time on a ward was six to eight weeks. One student thought that the initial long spell on a ward was not such a good idea because she became dependent upon the ward and thus, her first move was "like starting all over again". Another student, who was indeed in the minority, was looking forward to staying in one ward for some time.

'(...) the wards are very different, you go to different wards, you just have to fit in with what way the staff seem to run that ward and its awfully difficult. I'm getting to the stage where I would like to be in a ward for a little while - six months or eight months - and just be part of that ward - not just having to go to another one, adapt to their way of thinking, just get on and ... yes it is different in every ward'. (32)

The desire to settle was, however, by no means universal, the following extract is more representative of the students' views.

K.M.: So are you looking forward to being able to stay in one place when qualified?

Student: No (laughs) no, no because when I've done thirteen weeks in a ward, when I get to the end I think, I can't wait to see the back of this place. Not that bad, I feel after a while everything becomes (...) so monotonous, all you are doing is coming to work, doing your work, going home - just eating, sleeping and working. That's how it gets towards end, 13 weeks is the longest I've had, in gynae., just same every day, doing same thing.

K.M.: Another example of how your three years as a student is different from what you are aiming at. Your three years as a student you do have this variety and interest and yet really what you are aiming at is being a qualified person that stays in one place (...).

Student: True, yes. I don't think I'd like that, it worries me - well I still plan to do midwifery, I was going to do my district but I've gone off that slightly so I'll probably find sick kids (1) to do or something. I won't settle down to a staff nurse for a wee while yet. I don't like the idea of staying in one place, I think it would get very boring after a while (...).

K.M.: So you really have quite an adjustment to make once you've qualified, at that rate (...)?

Student: Yes, I think its because you are so used to moving around, if you had to stay in one ward for something like six months you'd be used to it (...) if you get bored with a ward and start not to enjoy it, think well I'm going to this next and look forward to that. (39)

On the whole, it seems that the student nurse training provides an unrealistic introduction to nursing, because of the implicit transiency in the three year course. One student summed up her feelings towards moving wards by saying to move was "sometimes a relief, other times I don't want to". She thought that it was the fact of transiency which enabled her to enjoy some wards.

Student: And I often wonder whether its the thought that, well, I'm leaving in a fortnight, makes me begin to enjoy it a bit more. You know I've often wondered if that's the thing that has kept me enjoying it.

K.M.: Whereas if someone said, right you are here for two years.

Student: Yes, would I be that cheery on the ward, I don't know.

K.M.: So how do you feel about eventually settling down somewhere?

1. Refers to Community Nursing training or Registered Sick Childrens' Nurse training.

Student: Well, I'm planning to do six months, hopefully, medical, six surgical and then go on to do midwifery. So I've still got the thought of it (moving) although I've got a few months. (35)

Thus, it seems that the students weigh the advantages against the disadvantages of settling down. They perceive the advantages as having to do with getting to know a ward well and experiencing a sense of belonging. The disadvantages, however, seem to be to do with having to stay in one place and risk boredom. The questions of belonging and boredom are taken up again below. For the moment, the students suggested ways out of this problem of settling down are considered. There seemed to be a tendency to want to go on and do further certificates. This might well be a direct consequence of the unrealistically transient introduction to nursing which the students receive. By planning to go on to take further courses of training the students were projecting the notion of transiency into their post-registration period. This desire to collect further certificates can be explained, in part, by the fact that the students have been used to 'passing through' rather than 'settling down'. However, it is a complex issue which can be further explored with the aid of literature concerning what Pape (1964) has dubbed 'touristry'.

Pape looks at a group of workers who engage in 'touristry', that is:

'a form of journeying that depends upon occupation, but only in a secondary sense, in that it finances the more primary goal, travel itself'.

In her study of these workers, American nurses, Pape suggests that orientation to nursing as a primary focus, in the sense of a career pattern, is by no means universal among younger nurses. She contends that such an orientation is tied to the passage of time and that career

oriented nurses are found in the older age bracket and in the upper regions of administration and education, whereas the younger staff nurses view nursing much more as a minor part of a whole life pattern. Among the consequences of such a difference in orientation, Pape argues, is the fact that the 'tourists' use different standards in evaluating the jobs: standards which have more to do with salary, social amenities and the potential pool of future husbands, than the professional standards which the career oriented nurses would employ.

Certainly a number of the students in the present study mentioned marriage and their plans to settle, but the data allow no more than passing comment. A suggestion offered by Dingwall and McIntosh (1978: 55) in an introduction to Pape's paper, is that the freedom of mobility which 'touristry' offers the nurse could be seen as some compensation for the lack of freedom in nursing and the restrictions of the work itself. A second point of theirs, which might have more to offer in terms of these data, is that the role of perpetual student carries with it a certain respectability. The data of this study suggest that one can conceive of 'nursing work' as distinct from 'student work'. The central activity, patient care, is common to both forms of work: the difference lies in the time scale and location of the work.

'Nursing work' is the province of qualified staff who settle in one area and become the 'permanent staff'. 'Student work' on the other hand is carried out in short spells of duty in a variety of wards and the distinguishing feature of its organisation is its transiency. When the student has come to the end of her period of 'student work' and become eligible to move on to do 'nursing work' a large number prefer to

continue with the 'student work' and so go on to do further courses and thus continue as student workers. There are several advantages retaining 'student work' and the accompanying status. A qualified member of a permanent ward staff, aside from her personal responsibility for her patients, becomes responsible for teaching students, managing staff and maintaining standards in her chosen area of work. A student worker, however, has a responsibility only for her own work. Because she constantly moves on from place to place, long term responsibility for her actions, in terms of general policy or educational programmes, is not expected of her. Parallels can be drawn between the student worker and the perpetual student in academic life. Both share a carefree existence being responsible only for their own certificate collection.

Dingwall and McIntosh (1978) suggest that there might be a "relationship between credential gathering and touristry as legitimate and illegitimate forms of mobility". The students in this study did not mention travelling in direct terms of 'touristry'. They talked in terms of seeing how nursing was done in other hospitals, or a further training. In so far as these data go they suggest that the main reason for retaining the student role had primarily to do with evasion of settling down. Interestingly, the students often equated settling down with a move away from the patients. This point is explored below in terms of the students' perceptions of the role of trained staff.

Students' view of 'nursing work'

The following section examines the differences between the student's life and that of the permanent staff, as seen through the eyes of the students. It was apparent after a number of interviews that the students perceived that there was a difference between the activities of the three years training to be a nurse and the essential work which a qualified nurse did. It will be recalled that student nurses are preoccupied with "getting on with the trained staff", to such an extent that many described this as their primary aim, while patient care came second. In exploring this notion of "getting on with the trained staff" the researcher discovered that not only did some of the students view their relationship with the trained staff as an 'us and them' dichotomy, but they saw the staff nurse's role as one which was very different from their own. To put it at its simplest, many students felt that they spent three years doing one job in order to qualify to do another. Moreover, a number of students were not attracted to the staff nurse role because they saw it as one which was removed from the patient.

As it has been said, the students' preoccupation with "getting on with the trained staff" was such that the students often measured their enjoyment of any particular experience in terms of how well they did "get on with the permanent staff".

There were, it seemed, certain factors which predisposed towards the students getting on with the permanent staff; for instance, if the staff were prepared to allow them to feel a part of the ward staff and not create the situation which the researcher has labelled one of 'us and them'.

Student: Its bad for students the fact that the same staff have been in the ward for years and years. Its very clannish, they might be very nice to you but still this three or four people who are the best of friends, been there for ages, and you are still an outsider.

K.M.: Who are these?

Student: Trained staff, or auxiliaries as well. Usually, they are very much in with the sister, very friendly (...). The sister tends to go to the auxiliary rather than the student. (10)

The student cited above described the feeling of being an 'outsider' in relation to the permanent staff on the ward. Another student described her experience in the Accident and Emergency Department which she enjoyed because, "everybody speaks to you, there is not so much discrimination there". She also made the point that in some areas the staff didn't talk to the students unless they had to. This was also true of medical staff, "except, of course, on night duty, when they had to speak to you because there was no one else".

The point that this student was making had more to do with the fact that she felt accepted by the trained staff, than simply that they spoke to her. The transient nature of the students placement on a ward usually meant that they were not treated as part of the ward team. This student qualified her remarks about getting on with staff being all important. When pushed to say what it was that made a ward or department enjoyable she said:

'the patients, it really doesn't matter if the staff are horrible, you can forget it and compensate by getting on with the other students. And, if you really hate it, well you are only there for a few weeks'. (20)

The students were, then, aware of the problems caused by the transient nature of their role. They were in a unique position on the wards, in that they were not qualified so did not have the status of the trained staff; neither were they permanent staff so they were in a different position from the auxiliaries. As one student put it:

'the staff are good if they are not cliquish, which they often are. There are problems with the auxiliaries and with the trained staff, we are stuck in the middle'. (18)

'Us and them' is a rather crude way of describing the relationship between the permanent staff and the students. Nevertheless, it is a phrase which does appear to sum up the kind of divide which many of the students felt. The students described the 'cliquish' or 'clannish' relationships which often existed among the permanent staff. It was often the case that the permanent staff formed a social group, which spent off-duty time together. As it has been suggested, the ward sister knows the capabilities of her auxiliaries and is thus, more likely to turn to them in order to 'get work done' than she is to students who she might have first of all to teach. This fact was mentioned by the students and, indeed accepted by them, in some part, as a reasonable way for the ward sister to proceed. One student commented:

'the staff accept you and explain things to you; in some wards it could be better. You can't expect the staff nurse to remember who has been shown what, on the whole, if you go and ask they will tell you'. (21)

This student's remarks add to the data which justify the trained staff's attitude towards students. Although the students did not like to feel 'outsiders' or indeed, to be passed over for auxiliaries, it does seem

that they had some appreciation of the difficulties which transiency presents for the trained staff. This is particularly true in the case of the ward sister. She is faced with a constant stream of students passing through her ward, her staff nurses do not, on the whole, stay for a long period of time, which leaves the auxiliary as the stable part of her nursing work-force. It is interesting to note in passing, the place and potential of trust in a division of labour. When the ward sister cannot carry out all the patient care herself, she has to rely upon the staff, trained and untrained, she has at her disposal. The sister has little chance of getting to know the students on a personal basis and hence has to fall back on the stereotype of the students which she fits into her available organisational slots, whereas she knows the capabilities of individual auxiliaries and will be able to make use of their labour on a basis of individual knowledge and trust as well as the structural features of the situation.

The data from this study clearly do not allow any more than speculation about the consequences of transiency for the trained staff. It is merely suggested then, that the auxiliary does not present any threat to the ward sister in terms of professional competence or desired independence; she is willing to do what the ward sister asks her to do, and hence is a reliable member of the nursing team. A ward sister who has been in one ward for a while may well find the ideas which students bring to the ward threatening or at least disruptive. She may also find that maintaining her staff nurses' loyalty is a difficult task should the staff nurse wish to act upon her own professional judgement and initiative. The ward sister is in a position to ride these

potential hazards by using the transient nature of the students' role as a justification for dictating and controlling their behaviour, by working the opposite shifts to her staff nurse and by giving her auxiliary a more prominent position than perhaps she otherwise might.

Passing out - staff nurse work

The final transition which the student has to make is that from student to staff nurse, and thus from 'student work' to 'nursing work'. It should perhaps be said that this progression is rather more complex than its linear model might suggest. The complexity is introduced by the inherent ambiguity, in terms of whether the student nurse is a student or a worker. Nevertheless, the transition has to be made, and the students described mixed feelings about it.

There is, in the training scheme, an official provision for the move from student to qualified nurse; this takes the form of a pre-registration period of six months. This period commences after the student has taken her state final examination and before she is allowed to register. This is designed to be a period of consolidation when the student should be given the opportunity to learn some of the management skills which she will require as a staff nurse. One student described her attitude towards her work if she knew that she was going to be in a senior student's or staff nurse position on a ward "my approach to patients would be the same, but my approach to junior staff would have to change - I'm told I'm too pally with the juniors". The researcher asked if she got the same results in terms of work by being 'pally' with them. "No, I don't get the same. If you're pally they tell you they don't want to do this and that, you've got to be authoritative to a certain extent".

One student discussed the difference between her student role and her future role as a staff nurse.

Student: (...) you're a student and then you are suddenly qualified. There is a big difference. I suppose you are on the other side; you are making the decisions as opposed to acting on someone else's decisions (...). I'm dreading the responsibility.

K.M.: I know you have the pre-registration block eventually, but, does there seem to be any kind of build up to it or is it really that you have spent three years doing one thing and suddenly, now you are it?

Student: Some wards (laughs), I shouldn't say this, when you are a pre-registration student, depending on what ward you are in, you can get into the office and have a cup of tea with the staff nurses, and that sort of thing. (30)

The idea of students occupying a marginal position during the move from student to staff nurse was explored. The indication of students being accepted into the edges of their ranks was substantively trivial; it symbolised the student's access to privileged areas of social interaction. For instance, the student above, who said that pre-registration nurses could get into the office for tea. Another student felt that she had crossed the barrier when she went for supper with the ward sister. Thus the students had some insights into their coming role and what it might be like. However, the transient nature of the student role had not, it seemed, prepared the students for the realities of staffing.

There was much discussion of the difference between the work of the staff nurse and that of the student. As it has been said, the crucial difference was seen to lie in the move away from the patients, which the students felt came with staff nurse status. Indeed, some students argued that this move began to occur when they were third year students. The logical consequence of the trained staff moving away

from patients is that is the students who carry out the nursing care. As one student put it:

'you spend three years being told what to do, suddenly you swap roles (...). I've heard students say "it will be great once we are qualified, we can sit back and do the paperwork and tell the students to do everything"'. .

The fact that the majority of the patient care is carried out by student nurses came as a surprise to a number of the students. These students had been under the impression that they would be working alongside the trained staff on the wards. This student in particular was very distressed on discovering the reality of the situation:

'I was shocked when I came to the wards and saw all the work done by students. I think that even if you are a trained nurse you should still be able to come down and do the basic tasks, that's what I see nursing as (...). I thought that the ward sister and staff nurse would muck in with you, I didn't realise that they were separate'. (30)

The student quoted above said that she did not want to become a staff nurse if it entailed leaving the patients in favour of the paperwork.

One of the striking features of the students' accounts of the staff nurses' role was the amount of potential discretion which they felt went along with it. Whilst on the one hand the students contended that the staff nurses moved away from patients, some were adamant in their view that this need not be the case. Throughout three years of training, students had become accustomed to seeing staff nurses doing a, seemingly, different job from the one which they were currently apprenticed to do. Many of the students thought that the staff nurses' role need not be handled in that way, others saw no alternative, and consequently did not relish taking on the staff nurse role. Those who felt that the staff

nurse need not be so divorced from the patients tended to feel that she should 'pull her weight'. The data discussed in Chapter 6 illustrate this point. The main argument being that if there is work to be done, all the available staff should join in and get through it, rather than leave all the heavy work to the students. The following comment sums up the students' notion of the discretion attached

'well, I think its really what you want to get out, if you want to back away from patients, you have got an ideal excuse'. (32)

The researcher pursued the question of a differentiated role for the ward sister, and to a lesser extent, for the staff nurse. The students seemed to place more value on the fact that the ward sister 'rolled up her sleeves' and 'mucked in' rather than her managerial activities. They suggested, for instance, that she "must be able to join in and organise", such comments pointed to the fact that the ward sister's separate function over and above the one shared by the rest of the nurses on the ward. One student said:

'when the staff nurse is in charge she has two roles; one working with you and one running the ward (i.e. organising and doing the clerical work)'. (25)

This student recognised the second function, which she ascribed to the staff nurse, as ward sister's work; yet if the staff nurse was 'in charge' in the absence of the ward sister it seemed that she should not, by this student's account, be allowed to relinquish her 'mucking in' role.

The students frequently referred to the 'paperwork' or 'office work' which forms part of the staff nurses' work. The 'office work' was often used as a justification for the move away from the direct care

of patients, which the students, on the whole, saw as part and parcel of the staff nurse role. Thus, it seemed that there were, in the students' eyes, three aspects of the work of the trained staff; namely, organisation of the nursing, clerical duties and participation in direct care. The first two aspects of the work were seen to be prestigious, whereas the third was viewed more in terms of 'helping out'. The following comments illustrate the point:

'Those who have enjoyed their training want to go on with nursing care, others sit back. It depends on the ward, if it is busy the staff nurse must be out working'. (25)

And, underscoring the point about prestige:

K.M.: Should the ward sister join in like any other nurse?

Student: Not like any other nurse, no, they have got promotion. They should get some benefits, maybe not benefits, maybe get out of doing the mucky jobs. (28)

This last comment not only suggests a ranking of nursing work, but a legitimisation, in terms of length of service, of a move away from the patients. It also suggests a distinction, in the minds of the students, between prestigious and lower grade 'mucky' work (cf. Hughes 1971, 'dirty work'). The notion of 'acceptable nursing work' is discussed elsewhere in the context of profession. It is mentioned here because it could help to explain why the students preferred to see the ward sister and staff nurse doing the same work as themselves. It is, to some extent, bound up with the idea that nursing work is not very desirable, and is seen in terms of a workload to be 'got through' (cf. Chapter 6). It could be that the students feel that they are being left to get on with the work, while the trained staff are allowed to escape it by claiming other duties. If it is the case that parts of

nursing work are construed as undesirable and 'dirty work' the consequences for patient care and the development of nursing might be important. The data do no more than hint at such a state of affairs in the shape of comments about the discretion attached to the staff nurse role. If newly qualified nurses are going to shun direct patient care, then it seems that there are serious questions to be addressed concerning who should do the bedside nursing. Is it to be left to the unqualified and the untrained?

If this is the case then the student has two alternatives; she can either take the same line and wait until she is a staff nurse and thereby shirk the routine care, or, she can re-define the staff nurse role and work with the patients. The second option would be going against the grain, according to the experiences reported by the students in this study. Whether the students would actually live up to their ideals, upon becoming qualified nurses, is, of course, another matter. It must be remembered that the staff nurse and ward sister roles are being discussed here as they are seen through the students' eyes. The incumbents of these roles may have a very different perspective, which might explain their behaviour in rather different terms. As it is, the students, on the whole, seemed to think that they spend three years doing the work in order to gain staff nurse status and, ipso facto, merely supervise the work.

Summary

This category has been concerned with the students' accounts of their work in terms of the frequent moves which they have to make and adjust to. From their early days in training the students pass from ward to ward and from clinical areas to college work in fairly rapid

succession. This transiency, it has been argued, has implications for both the attitude of the students towards their work and placements and the attitude of the permanent staff towards students. The students discussed the transient nature of their work in a very matter-of-fact way and indeed, seemed to accept it with resignation. Not only did the students manage to rationalise the way in which they were treated by the permanent staff, they also defined the permanent staff's behaviour as a reasonable reaction to the student presence. This tout comprendre c'est tout pardonner attitude characterised many of the students' accounts of their difficulties both on the hospital wards and in the college of nursing.

The constant moving and lack of settling in any one clinical area, it is contended, does not offer the students a realistic preparation for staff nurse work. This is yet another example of the inadequacy of anticipatory socialisation when examining the student nurses' training experience. The final difficulty with the system of training nurses is pointed up with the students' accounts of how they intended to avoid settling down as staff nurses. It seems that by and large their three years of transiency give the students an appetite for moving on rather than a yearning to settle down.

CHAPTER 10

Doing nursing and being professional

This category arose out of several, seemingly disparate, items of data. The students described the work they did in the hospital wards in various ways, but one frequently occurring phrase was that work in certain areas was "not really nursing". This caused the researcher to pursue the idea of what the students were prepared to call nursing and what they were not. There was also a tendency on the part of the students to talk about doing things in a 'professional' way. These remarks often arose in the context of discussions of job satisfaction, careers and how nursing differed from "just a job". After much perusal of the data it seemed to the researcher that there were some conceptual links between the data concerned with what constitutes nursing and what, for the students, makes nursing a profession. The explication of this category is an attempt to demonstrate these links and point up some areas for discussion.

Doing nursing

The question of what is nursing is one which provokes endless debate in academic nursing circles. The interest in developing a scientific basis for nursing practice has led to a steady growth in 'models' and 'theories' and 'conceptual frameworks' in the nursing literature (cf. Schlotfeldt 1975; Orem 1971; Inman 1975; McFarlane 1976; Roy 1974; Dickoff and James 1968) to name but a few.

Indeed Williams (1979) ⁽¹⁾ says that: "Identification of a conceptual framework has become a sine qua non for educators responsible for programs of nursing education". It appears then that there may be a tension

1. Williams in Downs and Fleming (1979:89)

between those who theorise about nursing in this way and those who actually 'do nursing'. This possible tension is explored in the light of these data.

It seemed that although the student nurses had no difficulty in talking about nursing in abstract terms, when they came to describe the different areas in which they had worked, 'nursing' was defined in a more pragmatic way. The extract presented below serves to illustrate the ways in which the students determined what was and what was not nursing.

Student: I think maybe you should get more encouragement during your time on the ward - you know, somebody saying 'you did that well' because it gives you a bit more incentive to work especially say in geriatrics and everything is more or less the same every day (...)

K.M.: Did you enjoy working in geriatrics?

Student: Yes, well when I heard I was going to geriatrics I thought its going to be a slow pace you know, because I had left surgical where you are busy all the time. But when I got there I loved it. I was a wee bit apprehensive about going.

K.M.: Had you been anywhere before the surgical?

Student: Yes, I had been in medical before surgical (...) Medical is quite a fair pace and surgical is even more but geriatrics is slower. It all depends on what's wrong with your patients (on medical ward) because if they are long-term patients you have got to do a lot more for them than if they are just waiting for Part 4 (residential care). When they can do a lot for themselves you don't really do that much for them apart from the odd encouragement, sometimes you feel you are not doing very much for them, they are just getting on with everyday life themselves.

K.M.: What did you feel about that, looking at it from your point of view as a nurse, did you feel that you were nursing them (...) ?

Student: You didn't really feel that you were nursing them because I suppose you always think of nursing as the more technical sort of things like your injections and dressings and giving out medicines and things like this, but I mean, geriatrics is really just basically nursing care, you know, very basic, keeping them clean. (2)

This student appeared to be equating fast moving, technical work with nursing; and so she did not "really feel that you were nursing" geriatric patients. In fact she went on to say that these older patients needed just basic nursing care. Thus, the fact that the patients were either physically independent and simply in need of encouragement, or not in need of technical care, but required only basic nursing care, made looking after these patients not really nursing. Discussions along these lines prompted the researcher to divide the student nurses descriptions of care into three main groups: viz 'Real nursing', which occurred mostly on surgical wards, happened at speed and involved technical procedures or drugs administration. 'Just basic nursing care', was the term used by the students to describe the situation where the care required was all nursing care, which was independent of medical prescription. It is distinguished as a separate type of care because of the dismissive tone in which the phrase was often uttered. 'Not really nursing' was the phrase most often applied to nursing in geriatric wards, or to elderly patients in medical wards, who were in need of social care, prior to an alternative arrangement being found.

These three kinds of care described by the students provide the basis for the following tentative explanation of how the students came to see much of the work which they did as "not really nursing". The students seemed to stand in need of external reference points from which

to judge whether or not their work could properly be described as nursing. The two main ones identified in the data were patient variables, notably age and severity of illness, and the location of the patient in terms of area of medical specialty.

K.M.: (...) So maybe just to start, what matters to you most in nursing, you know, when you are nursing a patient, what do you think is really probably the most important thing to you?

Student: How they feel, I suppose really. It really depends on the age group you're working with. Caring for them, you do the best you can, you know, to try and understand (...) if its old people, well you just want a basic nurse you know make sure they don't get sores and they are always clean. Because they like their pride and it gives them a wee boost and that. But really for younger people I think its more, well, looking after them and making sure whatever's happened to them is getting sorted. But I think with younger people its more understanding.

K.M.: Your understanding of them or to help them understand what's happening?

Student: Both, its sort of completely different really. You like, say a bed bath for an old person compared with a young person. Quite traumatic for the young person to have to have a bed bath (...)

K.M.: And how do you cope with the differences yourself? Do you have any preference for types of patients for nursing?

Student: I didn't think I could ever work with old people, but I've just spent nine weeks with them and, you know, its great.

K.M.: Can you say what you liked about it?

Student: I think, some of them were just model patients (...) they really sort of help us, the ward is all they know because it was all long-term patients that were there.

K.M.: So what did you feel that you could do for them, as a nurse?

Student: Well most of them, there was really nothing wrong with them, you know. I mean it was just like giving them an interest and, you know, even talking to them (...)

In contrast when asked what she liked about nursing younger people the same student said:

'Well the only young people I've nursed were in surgical and I suppose that all the interesting operations and that, plus when you're nursing people younger, you know, in your own age group, you seem to have a lot more in common'. (2)

This student made an immediate distinction between older and younger patients when asked what she thought was important in nursing. She also made reference to the medical aspect of their care; the old people just needed a basic nurse; whereas the younger patients' care was viewed rather differently - "make sure whatever's happened to them is getting sorted". She found it easier to nurse the young patients because they were closer to her age group and, thus, she saw herself to have more in common with them.

The pace of the work which related often to the nature of the condition, seemed to be an important factor for the students; it was also a factor which figured in their determining what was and what was not 'really nursing'. The comparison of surgical and geriatric wards made by the student quoted below makes this point.

Student: If you go from surgical to geriatrics then you've got problems, one extreme to another.

K.M.: How?

Student: Surgical fast, geriatrics a very slow pace, totally different kind of nursing.

K.M.: What sort of things did you feel you were doing that was nursing in a geriatric setting?

Student: Baths, big baths, always seemed to come back to bedbath and big bath, pressure care, oral hygiene, more occupational therapy trying to get your patients involved rather than just sitting all day.

K.M.: You said nursing is so different at the beginning that its hard to sort of generalise about it. Do you feel that that was as much nursing as the work you were doing on the surgical ward was?

Student: No I think on surgical you felt you were actually doing something for your patient, whereas in geriatrics you feel you are only trying to better the latter part of their life. (...) whereas in surgical you knew your patient would go back out, into the home environment.

K.M.: Is that just the age of the patient? Imagine if you were on a young chronic sick ward, constantly looking after paraplegics, multiple sclerosis - that kind of thing. How would you feel about that, day in day out, bed baths, yet they are a younger age group?

Student: I think again, it would be different nursing, maybe its just when people are old.

K.M.: Yes, that's what I'm trying to get at - is it because they are old, or is it because of the patient care that you are giving that makes it less like nursing?

Student: I find in geriatrics it is really very difficult, I like old people, in a surgical ward then you don't mind because you have other patients (...) you find you can give them time and the others. But when they are all together its hopeless, because you do something for one and they all want it, all jealous and envious of the one. Younger ones, chronic sick, multiple sclerosis, they have such a sad life in front of them, whereas old geriatrics, they've had their life, probably a good life (...)

K.M.: What would you feel towards them that you wouldn't in a geriatric ward?

Student: (...) give more consideration to the relatives. Sometimes in geriatrics you think the family could do a lot more than they are doing, just coming at visiting, show faces for half an hour (...) (18)

When the student elaborated on these differences it emerged that the question of the pace of the work was only one factor among a much more complex set of considerations which influenced her approach to nursing and, indeed, her conception of nursing. In the surgical ward she felt that she was doing something for the patient rather than just passing the time, which she felt was the case in the geriatric ward. This question

of doing something appeared to be important to the students.

It could be argued that the students take their lead from the medical work, which is going on alongside the nursing work, and use this as their external reference for the value of their own work.

The age of the patient seems to be an important factor in determining the student nurse's attitude towards the care of the patient. The student quoted above at first seemed to be saying that it was the monotony of the work, all bathing, which made the work in the geriatric ward both difficult to do and difficult to envisage as nursing. Yet when the researcher asked about the young chronic sick, the student shifted her argument and explained her attitude in terms of the patient's age rather than the care required. She was, however, prepared to concede that nursing old people in a setting where there were also younger patients was different from geriatric nursing; because she thought that nurses could then devote the necessary time to old people when there were not too many competing with one another for the nurses' time. This comment shifts the focus of the argument back to the heaviness of the work rather than the simple fact of the patient's age.

Alternatively, the actual setting in which the patients were nursed could be said to have some bearing upon how the nurses view the work there. Old people in surgical wards are candidates to receive 'real nursing' because they have a condition which the nurse recognises as having a legitimate need; following the medical lead. Similarly, care of the young chronic sick, which to all intents and purposes resembles that given to old people, merits the term 'real nursing' because of the way in which students view the young patients. The student (above) said

that the old person has had their life whereas the young chronic sick have a sad life. This led her to view the nursing of each group in a different way. Indeed, a moral judgement entered into the student nurse's justification for having a more favourable attitude towards nursing the young chronic sick than the elderly. The nursing actions were the same but the social context different; this caused the student to deem the younger patient to be more worthy of 'real nursing' than the elderly patient.

Thus, the reasoning underlying the classification by students of their work as nursing or not really nursing varies according to circumstances, social and situational. The situational argument is interesting in the light of the findings of Baker (1978) in relation to the care of geriatric patients. Baker coined the term 'honorary geriatric' to describe patients who:

'because their nursing care was indistinguishable from that received by patients whom the nurses defined as "geriatric" and who conformed to the geriatric stereotype in every particular except age'

were thus designated. Baker describes the care of patients of different ages within a geriatric setting. The nurses were, seemingly, able to transcend the situational dictates of a geriatric setting in the care of some patients. Baker cites one patient who, although in her eighties, was treated preferentially, and in a way which was not in the 'routine geriatric style'; this was because she had the status of a 'young patient'. She had lived for many years on the ward, after being admitted as a younger patient, and her original status had remained with her. The student in the present study appeared to require the older patients to be 'diluted' with younger ones

and indeed transferred to the younger setting of the surgical ward before the 'geriatric stigma' and the 'not really nursing' outlook could be removed from her conception of the nursing care. Baker suggests that in defining 'geriatric' we must distinguish formal meaning from subjective meaning. A formal definition includes all the patients on the wards designated 'geriatric'; whereas the subjective meaning of 'geriatric' derives from nurses' categorisation of particular patients as 'geriatric' on the basis of their possessing certain, usually discreditable, attributes. In the case of the student quoted above, it would seem that she took her subjective definition from a formal situational lead.

Most of the items of data, which lead to the formulation of the 'nursing' - 'not really nursing' distinction, were concerned with the comparison between work on geriatric wards and the more acute wards. These comparisons were made by the students in terms of doing something for the patient or, seeing rewards in terms of cure and discharge home. This concept of nursing is exemplified by one student who thought that patients should actually "look ill".

Student: When I did my geriatrics I didn't find it stimulating at all, I enjoyed it but I found that the patients never got a lot to do, just sat there (...). There were no activities to do for them, there was music and things like that but it was up to the students to make something happen that day. But you always felt when I leave here nothing is going to happen its just going to go back into the same old routine because to the auxiliaries that have been there for 25 years, run the ward their way (...). I didn't mind it but I didn't think it was nursing as such.

K.M.: Could you say what you do think nursing as such is, what has to go into it that makes it nursing?

Student: I don't know if you expect somebody to be ill, you know, look ill, for it to be nursing. A lot of the old people, they are not actually ill, they are there because they are a danger to themselves in the community. Maybe its just that, they are not ill and they don't, maybe need so much from you, it was more supervisory than anything else. I don't know, maybe it was just lack of physical care that you had to give (...) (31)

This student also makes the point that she did not feel needed in the situation where she saw the work as "not being nursing as such".

This is perhaps not too surprising because nurses, conventional wisdom has it, commonly make patients dependent upon them and feel somewhat impotent when they find themselves in a situation where the patient requires little of them.

So far, then, the data have suggested that the students preferred the technical aspects of their work and had a tendency to describe such work as 'really nursing'. Criteria used in the process of labelling work as 'not really nursing' or 'really nursing' it has been suggested, have for the most part to do with the location of the patient and various patient attributes. However, the data do suggest, as mentioned already in passing that the student nurses take their lead from the medical profession in determining which areas of care they are most prepared to value and consequently refer to as 'really nursing'. This medical influence is explored more fully below.

Medical dominance

Whilst it must be said that this was not always the case, the students did seem to require some medical or technical overlay in their work before they were prepared to sanction the care that they gave as being the real province of nursing. 'Basic nursing care' was often described in terms of "anyone can do it" and thus dismissed as "just basic nursing

care". One student put a rather different view, although this was the only one of this kind it is worth noting before the discussion progresses, if only to point up the fact that there is scope for differences of opinion. Asked what she thought constituted the nursing part of geriatrics, she described their 'social care' and said:

'keeping them occupied is nursing because they are in hospital to be nursed, and they require amusement so that is your job in that kind of work (...) whatever the patient requires is nursing'. (26)

This response represents a rather extreme nominalist approach to nursing, whereby whatever the nurse did became nursing.

Preference for technical, medically oriented work was evidenced by students favouring surgical wards.

K.M.: Have you any preference yet between medical and surgical?

Student: Surgical, I don't like medical it's too slow and patients are around for maybe months on end. In surgical you get a different side of it, the turnover of patients is a lot quicker than it is on the medical side; plus you see a lot more different things coming in (...)

K.M.: Is it the speed you like, or the variety?

Student: I think it's both, actually, I like the speed of the work and the variety of work. You're never just sitting nursing chest infections and M.I's (coronaries) which is all it seems to be down medical, or diabetics with undiagnosed diabetes coming in or diabetics coming in with infections (...)

K.M.: (...) Do you find that you nurse in the same way in medical and surgical?

Student: No, I've found it's different, totally different.

K.M.: What sorts of things are different?

Student: Up in surgical you have got a lot more observations to do on the patients than what you have on medical. On surgical I feel I got more responsibility. (4)

Another student when asked whether she had preferences in nursing said:

Student: I like surgical rather than medical.

K.M.: Why?

Student: Surgical is better than medical. Quicker turnover of patients, it's faster.

K.M.: Is that just the day to day pace?

Student: Yes, although medical care is just as fast in a different way. Treatments are faster in surgery, medical investigation takes a long time.

K.M.: Seeing results you mean?

Student: Mm, medical nursing could be good if you are there a long time so you could see results, but for us only there eight weeks, a lot of patients you don't see go through (...) (11)

The surgical wards, it seems, are preferable for some students not only because of the pace of the work, but because of the results which are, generally speaking, more forthcoming on surgical than medical wards. This preference is interesting, for one might argue that in the areas where the doctors are playing the 'sit and wait' game, as is often the case in the medical wards, there is more in the way of independent nursing care to be given. Whereas in the surgical wards, the bulk of the work is either done by the surgeons or is dictated by them; consequently there is little scope for nursing which is not dependent upon medical directives.

Freidson's (1970b:141) discussion of medical dominance is relevant here; it is a theme which is taken up again later. Freidson argues that:

'In the medical organisation the medical profession is dominant. This means that all the work done by other occupations and related to the service of the patient is subject to the order of the physician. The profession alone is held competent to diagnose illness, treat or

direct the treatment of illness and evaluate the service. Without medical authorisation little can be done for the patient by paraprofessional workers'.

If we accept Freidson's position, then it should perhaps be of little surprise that the student nurses look to medicine as a legitimating body, in order that they might determine which aspects of their work to value. Freidson (1970b:144-145) suggests that the division of labour in the health services, which is organised around the professional dominance of medicine, produces a social order similar to that provided by a bureaucratic division of labour. Thus Freidson says:

'The paraprofessional worker is, then, like the industrial worker, subordinated to the authority of others. He is not, however, subordinated solely to the authority of bureaucratic office, but also to the putatively superior knowledge and judgement of professional experts'.

This professional dominance argument, which Freidson uses in order to describe the relationship between medicine and other health care workers, including nurses, might be used to explain the student nurses' tendency to value medically dominated aspects of their work. The students were prepared to call the technical and largely medically prescribed aspects of their work 'real nursing' and to dismiss, as 'not really nursing' those parts of their work which are not dependent upon medicine. It seems that the students in this study were reflecting, in their attitudes, the hierarchy of specialties in medicine. ⁽¹⁾ These data allow no more than speculation; the relationship between the preferred clinical areas of nurses and the distribution of merit awards in medicine might repay further investigation.

1. See Shortell (1974)

If the current move towards nursing developing an independent body of knowledge, couched in nursing models and theories, is in tune with the nursing work done on the wards one would expect there to be a heightened interest in the areas which allowed scope for such developments in nursing rather than the medically dominated areas. Two possible explanations for this not, apparently, being the case are offered here on the basis of these data. These explanations are bound up with the dismissal of 'just basic nursing care' by some of the students which has been described above. If the nursing care, which has the potential for independence of medicine, is seen in terms of "anyone could do this", it does not appeal to nurses because it is either low status work or, not sufficiently interesting work. The remedy for both of these difficulties with nursing work is to be found in medicine. The students take their kudos from medically dominated work and maintain an interest in their work by introducing a theoretical element, pertaining to medicine. The question of the introduction of 'theory' to the student nurses' programme in order to sustain their interest in nursing has already been discussed. The following extracts illustrate the point for the purposes of the present discussion.

K.M.: You talked about being an extra pair of hands and we were just talking about what makes nursing nursing. Other students I've spoken to have talked about working in geriatric wards and just keeping the patients amused, get them out of bed and put them back to bed again and they say that's not really nursing. Do you find that what you do in different wards you could either say was nursing or was not nursing?

Student: Yes, well to a point yes, everything is nursing to me, in my depressed moments, I'm just going to leave - I've got to be Jack of all trades and master of none. (...) I mean things like, I mean some geriatric wards, in a way it's nursing at its essence, you're doing everything for that patient. (...) But the patient knows he's got a family, they

will go back and assume a normal existence. In a long-term geriatric ward there's nothing you have got to think everything for them, that is probably nursing at its best where you do everything for them, on the other hand you can get so unstimulated because you are getting nothing back, no results. Really it is a constant toil, really and no results and in a way its nursing, but its not nursing. On the other hand some of the work done in geriatric wards anybody could do it - you don't really need a very expert person but you could use it to the patient's benefit if you were really interested enough you know. (32)

These comments demonstrate the tension which exists for the students; geriatric nursing is seen at once, as something which can be done by anyone and as an activity which, if carried out by an expert, could benefit the patients. Typically it was the lack of reward or results and the tedium which caused the students to dislike geriatric nursing, or at least, to dismiss it as 'not really nursing'.

The student cited below found her rewards in the orderly way in which surgical wards proceeded:

'There is a lot of order, you get your patient coming in your ordinary admission for appendix or something, not an emergency, then you see them getting from really down after the operation to fine; whereas in medical wards patients come in with, say, hypertension you can't do much for them. Doctors do blood tests, you the drug therapy, we administer the drugs, fair enough, but as far as you are concerned they are virtually the same as when they came in. You find the medical wards get bunged up with stroke patients. I'm working in a medical ward at the moment, half of it is all stroke patients, that need everything done - which I suppose you could say is just like geriatrics. The other side is acute, it doesn't mix well, there is not enough staff to manage the two different aspects of it (...)' (36)

Similarly another student preferred surgery for the interest.

'You are on the go all the time and it is interesting, knowing all about drips and drains and types of operations, I was very junior when I first did surgical, I didn't really get told much just sort of left to get on, making beds and washing folk and that, but now (...) you are told

a bit more about the condition of the patients and this is really interesting; also types of operations'. (6)

These extracts illustrate the reliance on medicine to provide, for nursing, both interest and work of a higher status than 'just basic nursing'. The stroke patients, which the student says "bung up" the medical wards, it might be argued, have needs which could be met by nursing actions which are not dependent upon medical prescription. Yet, these patients do not appear to be popular with the students; they prefer patients who, by virtue of their medical condition, afford more in the way of visible results and hence, some kind of reward in exchange for the time nurses invest in them. It seemed not to matter whether these results stemmed from nursing actions, the mere fact that results were seen was sufficient reward for the student nurses. The nursing work on the surgical ward was seen to be closely associated with the doctors' work which produced the ready and visible improvement. Also, interest in the students work was provided by the possibility of learning about the operations and "all about the drips and drains". Such technicalities, it can be argued, are a means of sustaining the student's interest in the tedium of the routine work of a surgical ward.

The nursing literature concerned with nursing functions which are independent of the doctor is growing. There has been a move by a small, influential minority towards making nursing an academically respectable discipline. Yet, according to the students, ultimately much of the patient care, however it is planned using any number of theories and care plans, is routine and, at times, tedious. As one student put it:

'However far you go into the technical side of nursing you can't get away from basic nursing care. There is now much more theory that somebody on the ward must know, but you will always need nurses to do the basics'. (36)

This apparent dichotomy led the researcher to investigate the students' ideas in relation to the status of their work. It seems that 'just basic nursing care' is, at once, the core of nursing and so easily dismissed in favour of 'higher status work'. The students' accounts of their work, in terms of their relation to the notion of 'profession', are discussed below.

A note on 'profession'

Carr-Saunders and Wilson (1933), in their seminal work, surveyed a number of professions and thereby sought to describe the emergence of professions, the rise of professional association and the effects of state intervention and regulation upon the organisation of the professions. There has been an abiding interest in the sociology of professions; with work focusing on professionalisation, professionals within bureaucratic organisations and the power of professions.

(Etzioni 1969; Vollmer and Mills 1966; Scott 1966; Abrahamson 1967; Hall 1968; Freidson 1970; Johnson 1972).

The main concern of much of the work on professions has been to answer the question 'What is a profession?'; although this was never the explicit aim of Carr-Saunders and Wilson (1933:3) who state that:

'It is no part of our purpose to attempt to draw a line between professions and other vocations, we are not concerned to say what vocations are professions and what are not (...) Indeed, the drawing of a boundary-line would be an arbitrary procedure, and we shall not offer either now or later, a definition of professionalism. Nevertheless, when we have completed our survey it will emerge that the typical profession exhibits a complex of characteristics, and that other vocations approach this

condition, more or less closely, owing to the possession of some of these characteristics, fully or partially developed'.

Carr-Saunders and Wilson, whilst denying the production of a definition of 'professionalism', do come close to it with their "complex of characteristics". In adopting this approach to the analysis of profession they could be said to foreshadow the work of the attribute theorists. This has been the dominant approach to the study of professions. The attribute theorists' analysis assumes that a set of criteria can be identified and used in order to determine whether or not an occupation is a profession. These criteria have proved to be difficult to draw up; Millerson (1964:5) has produced perhaps the most rigorous list. Drawing on the work of others in the field, he produces a league table of professional criteria. He also offers a definition:

'(profession) is a type of higher-grade, non-manual occupation, with both subjectively and objectively recognised occupational status, possessing a well-defined area of study or concern, and providing a definite service, after advanced training and education'. (Millerson 1964:10)

This definition does not take us very far along the way to knowing what is meant when someone uses the term 'profession'. Particularly problematic is Millerson's use of the phrase "subjectively and objectively recognised occupational status". In an attempt to provide some basis for understanding the usage of 'profession' this discussion will focus on the work of Freidson (1970a and 1970b) and Becker (1970).

Freidson (1970a) provides a different leverage on profession from that offered by the attribute theorists. His analysis of the medical profession is drawn upon here. He sets out to present:

'an extended analysis of a profession (...) emphasis is on both sides of the meaning of the word "profession" as a special kind of occupation, and "profession" as an occupation which has assumed a dominant position in the division of labour, so that it gains control over the determination of the substance of its own work. Unlike most occupations it is autonomous or self directing. The occupation sustains this special status by its persuasive profession of the extraordinary trustworthiness of its members. The trustworthiness it professes naturally included ethicality and knowledgeable skill'.
(Freidson 1970a:xvii)

Freidson makes a distinction between 'professionalism', which he describes in terms of an ideology of profession, based upon a set of attributes said to be characteristic of professionals, and 'profession' which he defines in terms of structural distinctions. Professionalism, he says, seems able to exist independently of professional status.

Freidson's (1970a:82) major criterion for making professions distinct from other occupations is that they must have a position of legitimate control over work. This is clearly not the case with nursing which comes into the class of occupations which Etzioni (1969:v) has called the 'semi-professions'. These he refers to as:

'a group of new professions whose claim to the status of doctors and lawyers is neither fully established nor fully desired. Lacking a better term we shall refer to those professions as semi-professions. Their training is shorter, their status less legitimated, their right to privileged communication is less established, there is less autonomy from supervision or societal control than "the" professions'.

Etzioni adds the caveat that he does not use the term semi-profession with any derogatory implications.

Freidson's main thesis is that the consequences of the paramedical occupations being organised around the central established profession of medicine, are that, whilst on the one hand, they lack autonomy, responsibility, authority and prestige, they do, on the other hand,

possess elements of professionalism. Freidson (1970a:63) sums up the nurses' dilemma thus:

'while nursing originally established itself as a fully-fledged occupation of some dignity by tying itself to the coat-tails of medicine, it has come to be greatly concerned with finding a new, independent, position in the division of labor. One of its dilemmas, however, lies in the fact that its work can no longer be controlled by the occupation itself. Most nursing takes place inside the hospital where nursing has not achieved autonomy'.

For Freidson, 'professionalism' is the means by which:

'subordinate occupations claim to the public and to themselves that they have worthy tasks of service and evidence personal qualities of professionals ... indeed the claim is to be a profession as such, if only by identification with the profession of medicine'.
(Freidson 1970a:67)

It can be argued that Freidson's analysis is not all that different from the attribute theorists' work (cf. Dingwall 1977:119). Dingwall argues that Freidson having found his 'fundamental criterion' in professional autonomy uses it in his identification of other 'professions' in the same vein as the attribute theorists.

'There is a central ambiguity in his (Freidson's) work between specifying an objective definition of "profession" and examining the subjective knowledge of collectivity members (...). The strain between the objective and subjective elements is usually resolved in favour of the objective. This, of course, leads Freidson into legislating a social reality in just the same way as a classic attribute theorist'. (Dingwall 1977:119-120)

Becker's (1970) paper concerned with the nature of profession is now discussed. He cites Flexner's (1915) classic paper 'Is social work a profession?' in order to demonstrate the attribute approach to the study of professions. Flexner, he says, set forth six criteria for distinguishing professions from other kinds of work:

'... professional activity was classically intellectual, carrying with it great personal responsibility; it was learned, being based on great knowledge and not merely routine; it was practical, rather than academic or theoretic; its technique could be taught, this being the basis of professional education; it was strongly organised internally; and it was motivated by altruism, the professionals viewing themselves as working for some aspect of the good of society'. (Becker 1970:88)

On testing out his criteria against the attributes of certain occupations, Flexner found that social work had no technique of its own and thus was not a profession.

He then qualified his objective criteria drastically with the caveat:

'what matters most is professional spirit. All activities may be prosecuted in the general professional spirit. In so far as accepted professions are prosecuted at a mercenary or selfish level, law and medicine are ethically no better than trades. In so far as trades are honestly carried on, they tend to rise toward the professional level ... The unselfish devotion of those who have chosen to give themselves to making the world a fitter place to live in can fill social work with the professional spirit and thus to some extent lift it above all the distinctions which I have been at such pains to make'. (Becker 1970:88)

This caveat, in a sense, undermines Flexner's whole analysis; for it suggests that a profession is only a profession in so far as some sociologist is prepared to say it is. Becker (1970:89-92) suggests that the difficulties experienced among students of profession in trying to arrive at an agreed upon usage of the term "profession" stems from the fact that:

'one term is being made to do two quite different jobs'.

The term "profession" is used by social scientists as a scientific concept, in order that they might distinguish professions as one of several forms of occupational organisation in a society. Yet, Becker

points out, "profession" is not a term used solely by social scientists.

'Laymen habitually use it to refer to certain kinds of work and not to others, which they describe variously by "business", "sciences", "trades", "rackets" and the like. Used in this way in the ordinary intercourse of our society, the term has another kind of meaning. Instead of describing and pointing to an abstract classification of kinds of work, it portrays a morally desirable kind of work. Instead of resembling a biologist's conception of a mammal, it more nearly resembles a philosopher's or theologian's conception of a good man'.

Becker suggests that there is nothing wrong with using the term in both senses, that is to "use morally evaluative criteria to create an objectively discriminable class of phenomena". Yet, he says, that difficulties arise because people conventionally apply profession, in a morally evaluative sense, to certain occupations, typically medicine and the law. Similarly, convention refuses to allow the use of the term profession for certain occupations, Flexner uses plumbing as an example. Nevertheless Becker says:

'to some people, both those within the professions in question and laymen, it is not so clear that medicine and law are necessarily morally praiseworthy and plumbing is not'. (Becker 1970:91)

The problems surrounding the use of the term "profession" exemplify what Becker says is a perennial problem in social sciences; when the discipline's concepts refer to matters which concern both the people they are applied to and the general public.

'In an effort to make concepts abstract and scientific, we tend to lose touch with the conception of laymen. Yet, if we try to incorporate their concerns into our concepts, we are faced with ambiguities like those surrounding profession'.

Becker offers a way out of this difficulty and proposes that we should give up the attempt to produce a definition which is objectively specific whilst still conveying the layman's sense of which occupations are really professions. Instead, he says we should take a radically sociological view, regarding professions simply as those occupations which have been fortunate enough in the politics of today's work world to gain and maintain possession of that honorific title. In this way 'profession' is not used as a scientific concept but as a 'folk concept', that is as part of the apparatus of the society we study, to be understood in the way that society uses it. Becker goes on to look at what he calls the characteristics of the 'honorific symbol'. This analysis, he says, is different from the attribute theorist approach; for where they look at characteristics of existing occupational organisations, Becker is concerned here with "conventional beliefs about what those characteristics ought to be". He argues that:

'Although people disagree as to what occupations are "really" professional, (...) beneath these surface disagreements we can find substantial agreement on a set of interconnected characteristics which symbolize a morally praiseworthy kind of occupational organization'.

In order to effect this analysis of the 'symbol' Becker draws on the work of the attribute theorists on the grounds that these definitions tried to take account of popular conceptions and "furnish an adequate source of characteristics out of which to construct the symbol of profession in our society". He concludes that 'symbol' does not describe any actual occupation but rather, it is "a symbol that people in our society use in thinking about occupations, a standard to which

they compare occupations in deciding their moral worth". Becker recognises the limitations of symbols, particularly that they might become so removed from reality that they are unattainable.

Dingwall (1976) suggests that sociologists should seek to understand the 'practical usage' of 'profession', rather than attempt to legislate a correct use of the term. He set out to examine health visitors' use of 'profession' in relation to their own and others' behaviour in terms of 'professional' and 'non-professional' conduct. In this endeavour Dingwall drew up a summary of his field data in a schematic form. The resulting list included summary statements concerning the health visitor as a person, the autonomy of health visiting work, the attributes of the occupation, responsibilities for supervising others' work, equality of health visitors with other professionals, the discrete area of work of health visiting, and the health visitor's assumption that her view of her social location was accepted by others. The formal scheme drawn up from the data is not definitive or exhaustive but Dingwall (1977:122-123) claims that:

'Nevertheless by looking at the usage of terms over a series of interactions we may seek to assemble a repertoire which might plausibly correspond to some more or less organised interpretive scheme held by members of the health visiting community'.

This analysis, Dingwall says:

'involved abandoning any attempt to legislate the definition of a "profession" and, instead, the study of its usage to establish the activities of health visitors as a "profession" rather than an "occupation"'.
'

He concludes that:

'health visitors' claims to professional status are based upon their conceptions of the social structure of their society and the relative placing of occupations within it. This involves the location of health visiting as equal, inferior or superior to other occupations. Such self location is not, of course, necessarily recognised by those other occupations'.
(Dingwall 1977:141)

Dingwall's discussion of health visitors' claims to professional status is helpful in considering these data.

Students' usage of profession

Following Dingwall, the researcher looked for opportunities to explore the students' use of the term 'profession'. During the course of the fieldwork, the researcher gained the impression that the students used the term in an everyday sense, which took it for granted that nursing was a profession. In studying the transcripts, it appeared that the students used the actual word sparingly yet somehow managed to invoke the concept 'profession' in order to set nursing aside from 'just another job', or indeed, from the work of the nursing auxiliaries.

The students' limited usage of the term 'profession' presents an interesting question for analysis. The kinds of things the students were saying appear to amount to notions which sociologists would combine and label as a claim to profession; yet the students did not actually articulate this claim. In an attempt to produce the students' accounts of their world this analytic point is a noteworthy one.

Despite the fact that the students were apt to describe their work as 'not really nursing' and, implicitly, if in no other way, to suggest that a lot of nursing work required little specialised skill, let alone knowledge; the students referred to the work using the term

'professional'. Again it should be borne in mind that the students' usage of the word is of interest. It was used in many different senses, few in the tradition of Carr Saunders and subsequent exponents of 'profession'.

The following extracts illustrate the students' articulation of their work:

K.M.: Are you conscious of needing the exam at the end of the day? Of needing to pass it? Is it there all the time, the pressure?

Student: At the moment, yes. (The student was in college at the time).

K.M.: Do you feel it in the college more than on the wards?

Student: Yes, yes but I don't think its a bad thing, I think it would sort of sift out the ones that, I wouldn't want myself to be associated with, I think (...)

K.M.: Sorry, how do you mean?

Student: Well, I think, if you can't get through the exams, I think they have got to keep a certain standard in nursing. Even things like headlines in the papers "nurse found with several men" (...) it annoys me, it maybe sounds snobby but, it turns out to be an auxiliary or something. We are all classified as 'nurse'. We're not all, we are all nurses but there are definitely different categories.

K.M.: Its a difficult argument in some areas.

Student: Yes it is, but I think there have to be certain standards and people have to step in line with those otherwise, we are all going to go down with them. (...) you know, sort of a poor standard of nursing in a hospital, everybody is going to be classed as the same, so I do think the exams are essential. (34)

This student does not once use the word 'profession'; nevertheless she is making a claim for the separate categorisation of the occupational group. Indeed her comment about sifting out those with whom she would not want to be associated suggests that, although she does not use the term 'profession' she has some judgemental yardstick, akin to Becker's

'symbol', in mind. Her remarks suggest that she would reserve the term 'nurse' for a group of workers, who might do the same work as nursing auxiliaries but who are also in some sense different. This position was taken by several of the students. Whilst they could not always say why nursing either deserved a particular position in the classification of occupations, or was indeed, a profession, they displayed a tendency to want to set it apart as a rather special occupation.

The student's comments below illustrates the inability to define profession.

K.M.: (...) I don't know if you feel that it is more of a profession than a job?

Student: A profession.

K.M.: What makes it that?

Student: Its not just a job; you don't just go in and do it, it progresses. A job you just go in and do, come back and leave it. A profession you progress in, I can't explain it. (37)

Students' accounts of their work varied; some chose to discuss nursing in relation to occupational alternatives, as evidenced by the following extracts:

K.M.: (...) so in general terms, can you say what you think is important in nursing?

Student: Depends what you want out of it I think.

K.M.: You mean personally, can you perhaps say why you came into nursing?

Student: I've been working with people before in a public relations department, highways department, shops on Saturdays before I started nursing. I fancied working with people, I couldn't bear to be shut in an office all day, just didn't appeal to me at all, boring. So either nursing or teaching,

I did decide when I was doing my 'O' grades; the careers mistress informed me that there weren't many jobs going but there were opportunities to go into nursing in various parts of the country, so I decided to do nursing.

K.M.: How have you found it since you started, what do you like about it?

Student: I like working in the wards but I didn't realise that there would be so many exams and things (...) (28)

Similar views were expressed by another student:

K.M.: (...) What do you really think is important in nursing?

Student: I think you have got to have a liking for people, working with people got to have a compassion towards people. I think nursing will have to put out a lot more advantages of coming into nursing in the future; as far as I have seen on the wards they are really short staffed.

K.M.: What brought you into nursing?

Student: I wanted a job where I could work with people and I wanted to get away from home that's maybe my main reason, and nursing just seemed to be a job which suited me, but I've found out to my cost it isn't the job that suits me.

K.M.: Can you elaborate on that?

Student: Well for one thing, coming away from home I find I can't live on the salary, I'm overdrawn every month, I think that is just coming away from home. And you are given more responsibility on the wards than I think you can cope with and I don't like working shifts. (4)

The students cited above discussed their reasons for 'doing nursing' in terms of the attractions of the work in contrast with other possible occupations. Social and structural considerations, which had to do with conditions of work and the lifestyle which could be achieved through the work were important when these students gave their views of nursing.

K.M.: You said at the beginning that the thing that you thought was most important was caring for your patient and caring for your profession. Do you see nursing as a profession - how do you view nursing?

Student: Oh yes I definitely see it as a profession. And I think if we are going to have any advancement - there have been so many advances in medicine that nursing has obviously got to follow - and if we don't start banding together and sticking up for ourselves as a profession I think we are going to lose all status. As it is I don't quite know what our status is within the general public, how they feel about us. I'm sure the almost condescending way they say 'oh you do such a wonderful job', really they mean, 'I don't really know how you can do it, it is so horrible, but we need someone to do it so you must be wonderful'; that comes out in a lot of peoples' attitudes. It's a very middle class profession, so many people become student nurses and they are always fairly well educated, not just a lot of people who have got a couple of 'O' grades, they have managed to go on and do 'Highers', and quite a few of them have even been to university and colleges and then decided to go back to nursing because they have decided that they don't want a more 'classical' type of education, but want to be doing things with people. Nursing seems to be a middle course for most of them, they like to have responsibility, and at the same time be looking after people. In that way nursing is good (...) (33)

In the first two extracts above the students were talking about nursing in terms of job expectations and job satisfaction. The desire to work with people, not surprisingly, cropped up in most students' accounts of why they chose nursing. The student in the last extract defended the status of nursing work. She saw nursing as a profession for the educated middle classes who want a responsible job with people, but do not want a university type education. She stressed the point that many student nurses are eligible for university entrance. This comment stands in rather sharp distinction from that made by the student who was surprised to find that nursing was 'so academic'. The same student went on to discuss the work of auxiliaries. She felt that there should be more qualified staff actually doing the nursing care.

K.M.: (...) that doesn't quite square does it with what we talked about earlier, about how nurses say that they want to work with and help people; now we are talking about they want to move away from patients (...)

Student: Yes, if you really wanted to work with people you would be an auxiliary because they are the ones that always work with people, they never progress so they are always with the patients. That's why perhaps nursing should perhaps be changing more, there should be less auxiliaries about - and I'm always changing my mind about what should be done - but in some way there should be more trained staff and less auxiliaries, so that there are more trained people looking after and doing the basic care for the patients, and always doing the baths and bedbaths.

K.M.: Yes, because the picture that you are painting suggests that the students do that (i.e. basic care), and if there are trained staff there and students, the staff are happy to say 'oh well, the students should do that because they are here'.

Student: Yes, and some of the trained staff they even prefer to be doing things like just making empty beds, rather than doing basic things like beds and bedbaths; which is so wrong, because you always learn so much about the patient in intimate surroundings, you just get to know them so well (...) Maybe it is a time we got back to basic, more basic nursing.

K.M.: Raise the status of it, I wonder if that is at the root of it; a drug trolley is high status, washing somebody is not so good.

Student: (Heavy with sarcasm) Yes, anybody can do that, whereas only trained staff or two students can do the drugs (...) I think things are a bit upside-down. (33)

She went on to say that senior student nurses displayed the tendency to move away from the patients even before they joined the ranks of the trained staff. They preferred to do the more technical work and to leave the basic nursing to the up and coming juniors; this point was a recurrent one throughout the study.

The researcher pursued this question of the students' desire to move away from the patient, by asking how far the students thought that this desire was in keeping with the 'professional' ethos, or even the claim to want to 'work with people'. In the extract quoted above the student thought that "things were beginning to get a bit upside-down".

By this she meant that nursing was being done, in the main, by untrained nursing auxiliaries and students, instead of by qualified staff. In other words if students come into training in order to nurse patients when they qualify, why is it that they appear to move away from direct patient care as they approach qualified nurse status? This question also interested the researcher.

The students are faced with a problem when they consider the nature of their work. The student cited above exemplifies the tension which exists, when she tentatively suggests that there should perhaps be less auxiliaries. It seems then, that in making claims to 'profession', if indeed they are, the students are left with a dilemma. If they declare that nursing is a profession, which requires training, and has a body of skills and knowledge, they must reach the conclusion that untrained auxiliaries should not practise nursing. On the other hand, it is the case that auxiliaries do engage in very similar work to that undertaken by many students, thus the latter might equally well argue that if auxiliaries can do nursing it is not specialised work and therefore cannot be considered to be a profession. Malcolm Johnson (in Hardie and Hockey 1978:115) supports this second view, in a paper concerned with 'nursing professionalisation'.

'Perhaps the greatest stumbling block to professional elevation is the vast range of work which goes on under the nursing rubric. Nursing auxiliaries are not only numerous, they carry out work of an undeniably important kind with little or no training'.

This dilemma raises the original questions posed by Becker (1970) surrounding what is meant by 'profession'. We shall return to this question after considering one other aspect of the students' approach to 'doing nursing'.

The notions of 'getting through the work' and 'pulling weight' have been discussed in Chapter 6. This approach to doing nursing is relevant here as it has implications for claims to profession. It is convenient here to summarise this approach. There was a tendency for students to regard the nursing care as a 'workload' to be got through, and the nursing staff as a 'work-force' to get through it. The students talked of other nurses or students not 'pulling their weight', 'skiving' or not 'mucking in'. This was the picture of nursing which the students painted; it might be captured in the approach to work of one hypothetical student (idealised pastiche of the views of many). "I'm prepared to get on with a fair share of this nursing work, if you will get on with yours; if we all work together the sooner we will be finished".

It must be said before going any further that this summarised approach does not seek to deny the existence of finer feelings of altruism among the students. It merely demonstrates the ambiguities which exist in their approach to nursing; it is simply that reasons for being nurses and the hospital system of work are confronted here. The extract below illustrates the point.

K.M.: One of the things that has come out of these discussions is the idea that nurses are not really wanting to do the work (...). It's alright if all the nurses go out and do it, which fits in with the idea that it is alright if the ward sister rolls her sleeves up and the staff nurse will help, in a 'let's go and get on with it' way (...). That approach put up against the idea of being a caring professional nurse (...) seems like a different thing, one way it sounds like the conveyor belt and the work-force comes in (...)

Student: It is a bit like that though.

K.M.: I'm not saying it in a derogatory sense, maybe it is the only way to see nursing practice. I just wonder if we are not setting up a complication to make it sound like something terribly professional and special.

Student: I think it is a very important point, the other day we were talking amongst ourselves about how people see us and how we felt. It was to do with that programme 'Angels' (a B.B.C. drama serial) (...), we were thinking they are degrading our profession, we were thinking in a professional way and then started talking about how people see you. People ask you what you do and you say a nurse and they say 'oh, I could never do that'. And you think what exactly do they mean; do they mean that they wouldn't like to clear up all day, or, I really admire your patience and understanding. And then you realise that they have a false impression - mop brows and clear up. They don't know that there are a lot more technical things that have to be acquired (...) There are a lot of complicated things and it does take a lot of teaching as well as the way you treat people, and the general care and attention (...) (29)

This student immediately rose to defend the title 'profession' for nursing. The researcher's suggestion that to claim profession merely clouded the issue, was rejected by the student who went on to adduce evidence, in terms of "complicated things" in nursing, in support of her claim to profession. Her comment upon the public image of nursing is interesting. She suggests that the public may not, indeed, see the nurse as a member of a profession, but simply as a 'noble soul' doing a dirty job and therefore standing in need of praise. This attitude verges on patronage.

Discussion

To return to the original question concerning what the students meant by 'profession'. The data support the suggestion that student nurses are prepared to describe nursing as a profession, rather than any other type of occupation. What is not quite so clear is upon what grounds they do this. The nature of the work, they would admit, is at times basic and requires little skill; an argument which they support by reference to the fact that unqualified auxiliaries are often doing

the same work. Dingwall's discussion of claims to professional status is of some help here.

Dingwall (1976) suggests that the health visitors' claim to 'profession' which he interpreted as a claim to "a particular kind of social location in relation to other social groups", is not without its problems. In making this claim the health visitor encountered problems which Dingwall describes as "problems of exclusion and inclusion". Exclusion, in his context, has to do with defining oneself as a discrete occupation; in the case of Dingwall's health visitors, the work of general nurses and social workers created problems of this kind because their work overlapped with that of the health visitor. Problems of inclusion were posed, on the other hand, by the fact that the occupational groups from which the health visitors wished to distinguish themselves, in terms of work, were the same groups with which they wished to be identified as social equals. Clearly the doctors formed such a group.

The students in the present study are faced with the overlapping of auxiliary work and their own; the auxiliaries being an occupational group from which they wish to distinguish themselves. The data do not provide any clues as to how the students thought that they should rank socially vis-a-vis such occupational groups as the doctors. However, their use of the term 'profession' was indicative of some judgemental process occurring. The students were either using 'profession' in order to claim some moral respectability for their work (cf. Becker 1970); or, as Dingwall suggests in the case of the health visitors, in order to claim social status within the hierarchy of occupations.

The data do not allow any further comment upon which of these alternatives more closely resembles the students' motives. The students certainly seemed to be saying that nursing was in some way different; not 'just another job'. However, in the absence of comparative data, it is impossible to say whether this particular claim is in any way unique to nurses. There could be said to be an analytic distinction between two kinds of claim to being 'different'; firstly, claims being made on the basis of the work being service oriented, and thereby linked with 'profession' on altruistic grounds. In this sense nurses could claim 'differentness' because they work with sick people, and are thus in a position of privilege and trust. Secondly, claims to 'differentness' from other occupational groups might well be made on the basis of creativity or craft. The craftsmen who produce works of beauty through skill and long-standing practice, might claim that their work is 'different' from production line work; for example, hand-made reproduction furniture craftsmen as opposed to high street mass produced furniture workers. Thus the student nurses' claims to doing a 'different' kind of job, not 'just a job', do not necessarily tell us anything about nursing as occupation or profession. In the light of the above discussion, we cannot equate student nurses' claims to 'differentness' with claims to profession.

In this chapter the students' accounts of what constitutes nursing work have been considered. The students are prepared to call certain aspects of their work 'not really nursing'; the aspects of their work which they are prepared to call nursing tend to be of a technical nature. It has been suggested that this is not unrelated to the

possibility that nurses take their kudos from medical work, which is of a more technical nature. 'Real nursing' and 'not really nursing' as a distinction, can be defended by the students, broadly in terms of the age of the patients. Old people who simply need looking after rather than medical attention do not, the data suggest, merit the 'real nursing' which the acutely ill patients deserve. It could also be argued that the students find it easier to nurse the younger patient, who passes through the ward more quickly, and rewards the student for her efforts by improving and going home. It might be that the student can empathise more readily with a patient who is simply passing through on his way to recovery, than with the long term chronically sick. This factor might also go some way to explaining why the students tended to have a preference to acute nursing in the surgical sphere. In short, it may be easier to empathise with a younger patient who has a transient, curable condition.

Finally, there remains the question of profession, on the one hand, it seems we have a large work-force consisting, for the most part, of the unqualified and the untrained, (students and auxiliaries) doing the nursing on the basis of medical prescription. Whilst on the other hand, a small, but ever growing, academic faction are promoting nursing as a profession independent of medicine. How are the two to be reconciled? The data of this study allow no more than speculation on the part of the researcher, in the form of possible extrapolation from the students' accounts of profession. It is suggested here that the growing literature concerned with nursing theory is produced by and serves the needs of a professionalising elite in nursing, which is remote from the mainstream.

The behaviour which the students in this study describe as 'professional', it is argued, is no more than a result of the 'professionalism' which they claim through working in the shadow of the medical profession. Freidson's work is helpful here. He maintains that the fact that the paraprofessionals are subordinate to medicine is made more acceptable to them by their claim to professionalism; this would seem to be one explanation of the position which the student nurses in this study describe. In the light of this discussion, it ^{is} argued here that the tension between the professionalising claims of the nursing theorists and the claims to professionalism by these 'doing nursing' is not as problematic as one might at first suppose. For, far from being two opposing perspectives on the same phenomenon, they are, in fact, analytically different claims. The professionalisers, it could be said, are discontented with their lack of autonomy; and are striving to achieve professional status in their own right. Thus, nursing diagnoses, prescriptions and independent practice, in at least some areas of nursing, are the ultimate goals of this group. Whilst those claiming professionalism are content to obscure their lack of professional status proper, and settle for the status conferred upon them by virtue of working in close association with the medical profession. In Freidson's words:

'paramedical occupations hold a distinctly subordinate position in a complex division of labor, dominated by a profession, a position whose character is at once obscured and made palatable by the claim of professionalism'. (Freidson 1970a:70)

The data concerned with 'being professional' presented in this chapter, have been discussed in terms of Becker's notion of a 'folk concept' and Freidson's analysis of profession. The folk concept focuses on the meaning intended by those who use the term, in this case, student nurses. Freidson's work was drawn upon firstly, because it provides some possible explanation of the students' use of the term 'profession' from an alternative angle to the folk concept, and, secondly, because he discusses nursing in terms of profession and in relation to the dominant profession of medicine. The issue of professionalisation is taken up again in the next chapter.

CHAPTER 11

Concluding analysis

In this study the researcher set out to see how student nurses viewed their work and training. Thus far, the students' accounts of their nursing world have been presented; the major themes from the data explored and set out in analytic categories described in Chapters 5 to 10. The task facing the researcher in this chapter, then, is to examine these categories in order to discover what they tell us about nursing as it is understood by the student nurse.

It has been observed already that the analytic categories are not discrete entities. There are many ambiguities, overlappings and interrelationships which, for clarity of presentation, had to be resolved by producing distinct categories. The ambiguities in the data were at once analytically problematic and encouraging, the latter because they reflect the complexities of nursing. Often in writing about one category or analytic theme the researcher had difficulty in sustaining one line of argument as the concept under consideration had implications for other parts of the analysis. Preservation of the essence of the data and the tenor of the argument, whilst acknowledging the interrelationships in the analytic categories created are ever present problems of analysis. To summarise and attempt to draw the categories together would not take the discussion of the students' world much further forward. It is the intention in this chapter, therefore, to focus upon three issues which emerged from quite different substantive discussions during the fieldwork; each of these issues has already been discussed under more than one category heading. The issues demonstrate the interrelationships among categories insofar as disparate data items could result in one category and different categories could be developed from similar items of data. Also, it

seems reasonable to suppose that these issues are firmly grounded in the data and merit discussion beyond their original exploration in the categories.

The issues to be discussed are, firstly, how the student experience prepares the student nurse for staff nurse work; secondly, the interchangeability of students and nursing auxiliaries; and, thirdly, the notion of medical dominance in the students' world. Before proceeding to consider each of these issues it is necessary to elaborate the analytic concept of 'fitting in', which permeated all the categories. This concept, which has so far been alluded to only indirectly, was developed in order to explain one of the students' main concerns, namely, meeting the expectations of those with whom they worked, especially those in authority.

'Fitting in'

Throughout the interviews the students referred to their need to meet the expectations of those with whom they worked. On the hospital wards this meant, first and foremost, fitting in with the way in which the ward sister ran her ward. The wards were, according to the students, in one sense similar, in that the 'external routines' were similar; they differed in terms of 'internal routines', which were, by and large, determined by the ward sister. The students felt that they had to find out what the sister expected of them and to 'fit in' accordingly. The ward sister's expectations were not, however, the only ones to be met. The other qualified staff on the ward frequently had a different set of expectations and the students found themselves having to accommodate these. A major force with which the students had to contend was the body of nursing auxiliaries. These permanent

members of the ward workforce were seen to be set in their ways, usually older women, and, invariably, very close to the ward sister. The students soon discovered that to 'fit in' with the auxiliaries was not only expedient but almost an imperative.

From this brief discussion of 'fitting in', and there have been many examples of this in the explication of the six categories, it can be seen that 'fitting in' constitutes a major part of the students' behaviour. The student meets the expectations of her tutors, ward sister, permanent qualified, and, importantly, auxiliary staff on the wards. The student has only a short time in which to effect this. As it has been discussed, the transient nature of the student's role, means that she does not remain for much more than six or eight weeks on any one ward. Consequently the students concentrate their efforts firstly, on fitting in with the staff and secondly, on the actual patient care. There are sound reasons behind this seeming mal-ordering of priority. The ward sister has at her disposal a potential sanction, in the form of the student's ward report. Thus, the student has both her day to day comfort at work and her ward report, which constitutes part of her assessment, to consider in her dealings with the ward sister.

The students were very much aware of the fact that if their time on a particular ward was to be trouble-free, they would also have to get on and 'fit in' with the auxiliaries. The auxiliaries occupy a powerful position in the ward, because they tend to be long standing members of the hospital staff; a fact which often leads them to develop a close working, and sometimes social, relationship with the ward sister. The students relied on the auxiliaries for guidance in their first few days on a ward. They also knew that if

they were to antagonise the auxiliaries, their position might become uncomfortable. The students were suspicious of the close relationship which often existed between the sister and the auxiliary; and so felt that unfavourable comment might find its way into their ward reports.

Whilst most commonly the discussions of 'fitting in' referred to work on the wards, the students were aware of the need to know what constituted the 'college way' of nursing. They gave much more emphasis, however, to their 'fitting in' on the wards. 'Fitting in' is then, an important, if relatively simple concept. Throughout the fieldwork it recurred as one of the major preoccupations of the students. Indeed, they often used the expression 'fitting in' themselves when discussing their work on the wards. It serves then as a backdrop to the discussion of the main issues in this chapter.

1. THE STUDENT EXPERIENCE

This section is concerned with the appropriateness of the three years spent as a student for the eventual work as a staff nurse. In other words, how does the student experience help the newly qualified staff nurse in her work; that is to do what one student called 'a different job'. Can these three years of 'fitting in' prepare the student to be a qualified nurse?

From the data already presented it can be seen that the students become adept at moving from place to place, they adjust, pick up the routines and 'get the work done'. Alongside this practical experience, the students have lectures and tutorials in the college. The teaching, according to the students' accounts, tends to be disease oriented and medically dominated. Furthermore, this is presented with

a framework of an individualised care approach to nursing. However, on the wards the students have found that care is carried out in the form of routines and the work often split up into simple tasks which militates against an individualised approach. However, where there was a requirement for more complex technical work this was, on the whole, carried out by senior students and the staff nurses. To effect the organisation of work along these lines a qualified member of staff allocates the nursing work on each shift, in a way which has been likened to the 'scientific management' approach which is common in industry. This involves a degradation of labour, and a divorce of the specialist knowledge from the actual carrying out of the tasks; in this way a less skilled work-force can effect the work (Braverman 1974); the exception being the specific instances where complex technical skills were required. The student nurse spends three years on the receiving end of this style of organisation; on becoming a staff nurse she must also become, in the absence of the ward sister, a manager. The questions posed here are: how does she make this step from 'worker' to 'manager' and how is she prepared for this?

Socialisation

It has already been argued that the reaction approach to socialisation, which focuses on the student rather than the professional role, is appropriate when considering the socialisation of the student nurse (Olesen and Whittaker 1968, Becker et al 1961, Simpson 1980). The 'fitting in' behaviour described by the students in this study supports the notion that students temporarily abandon their long-term,

altruistic, professional-type goals in favour of meeting the requirements of the moment. Becker et al (1968:422) say of the medical students they studied:

'We believe that the medical students enter medical school openly idealistic about the practice of medicine and the medical profession. They do not lose this idealistic long-range perspective but realistically develop a "cynical" concern with the day to day details of getting through medical school'.

Psathas (1968) in a study of student nurses took a different view from Becker et al. Psathas prefers not to assign either values or motivational significance to the attitudes of the students; rather, he sees expression of a 'realistic' or 'cynical' approach to work as "indicators of successful socialisation and of the adoption of relevant perspectives rather than as situational adaptations".

Despite their different analyses both Becker et al and Psathas describe the ways in which the students behave in the face of the realities which they encounter during their process of 'becoming' doctors and nurses. The tactics which they describe represent the students' attempts at 'getting through'.

In this study the notion of 'getting through' has to be seen in the context of working on the wards, getting satisfactory ward reports and passing examinations. Interestingly, the students made very little reference to the written examinations which they had to pass in order to achieve registration. They appeared to consider themselves to be part of the work-force on the wards and were therefore much more oriented to 'fitting in' and 'getting through' there. The student experience in the college of nursing, it could be argued, is inappropriate for the preparation of staff nurses on two counts. First,

it does not offer a style of nursing which accords with the reality of life in the wards and second, it does not prepare the students for this discontinuity. These shortcomings of the college education could go some way to accounting for the students' seeming ambivalence towards the need for a theoretical basis for nursing. As it has been discussed (Chapter 5) they would argue on the one hand, that the auxiliaries did the same work and could function as well as student nurses; yet, on the other hand, that some 'theory' was needed for nurses. The need for theory was defended in a variety of ways, mostly pointing towards a claim to 'differentness' for nurses vis-a-vis auxiliaries.

The researcher can only speculate about why the students placed little emphasis on written examinations. When these were mentioned, it was in a general "exams make me nervous" sense; rather than in any attempt to discuss their relevance to registration. In contrast, the medical students in Becker et al's (1961) work tried to approach examinations in an 'intelligent' way, by electing to learn topics which would be of use in subsequent practice as well as get them through their examinations. There were too many topics and subjects to cover and so the Kansas medical students were faced with making choices about what to learn and what to leave out. Eventually, Becker et al argue, the students concern themselves with discovering what the teaching staff expected of them, and then concentrated upon learning that.

'they must decide which of the many facts they are brought into contact with they will try to remember and make use of; for a while some students try to make this choice by thinking ahead to their prospective medical practices and seeing what will be most needed there. But they know nothing of medical practice so this is not a workable criterion. What is much more

pressing is their discovery that they must first of all pass the examinations set for them by the faculty; if they do not they will not practise medicine at all' (Becker et al 1961:423).

The different approach to the 'theoretical' ⁽¹⁾ part of the student experience in the present study and that found in Becker's work is interesting. The medical students take for granted that all of the theory they are taught is of some use but suppose that some parts will be of more use in their future practice. However, as Becker points out, the medical students have little experience of practice so are unable to select which parts to learn for examinations using future utility as a criterion of selection. They were, however, able to discover what the faculty expected them to know and concentrated on learning that; this tactic resolved their difficulty in selecting topics to learn for examinations(Becker et al 1961). The student nurses in the present study are familiar with nursing on the wards and, therefore, are also aware of the fact that the 'theory' is of little practical help to them. The student nurses know what the college expects of them in terms of examination performance; what they are much less sure of is what the ward sisters expect of them in terms of practical performance. Thus, on the basis of these data it is suggested that the student nurses' emphasis upon 'fitting in' and 'getting through' on the wards is appropriate to their situation.

There is an interesting question of power behind this issue. The student nurses were not always sure just what was expected of them by the individual ward sisters; this they had to find out when they reached the ward. Also, the students clearly had the impression that the sisters either liked or did not like certain students and that this

1. 'Theoretical' is used in the sense of the 'book work' part of the course

had as much to do with personality as with anything else. Thus, the students were really charged with the task of meeting the expectations of those above them both on the wards and in the college. However one construes the students' position, that is as students, workers or apprentices, their progress is contingent upon their creating a favourable impression upon those above them. Evidence of the students' concern to make this good impression has been presented already. One frequently occurring comment bears repetition. The students were reluctant to complain or to seek support from their tutors or ward sisters over matters which concerned them. Their reason for this reluctance was to avoid any adverse comment in their file or ward reports. It seems, therefore, that the students faced their lot with a degree of resignation; they were prepared to 'fit in' and 'get through' for three years in order to become registered nurses.

Student to staff nurse

As it has been said, Becker et al (1961) suggest that students come into a profession with an idealised view of the attitudes, values and knowledge of its members. By means of interaction with the members of the profession and an exposure to its teachings the students can adjust their ideals by reference to the reality. It is argued here that the major difficulty facing the student nurse is a practical one of how she will function as a staff nurse. Thus, the main thrust of this discussion does not so much concern how the student nurse adopts professional attitudes, values, and the like; but rather, how she learns to function as a staff nurse. This is an important question to address as the eventual achievement of registration and qualification

is the aim of the three years spent as a student.

The 'professional' role, towards which their socialisation is aimed, does seem to the students to be different from the student role which they have taken for three years. Different, not merely in terms of status but in terms of content. According to the students' accounts, the staff nurse's work is further removed from the patients, especially when she has to take charge of the ward in the absence of the ward sister.

It has already been noted that the idea of anticipatory socialisation is not a particularly helpful concept in considering the student nurse's training for her work as a staff nurse. The students when faced with questions about how they might deal with a situation when they were staff nurses, tended to take a 'cross that bridge when we come to it' approach. This can be taken as an example of the students' tried and tested method of 'getting through'. That is to say, a student upon entering a new situation, finds out all there is to know about it, and on the basis of the facts as she sees them, determines her action. To be sure, she will build up a stock of responses to situations which she knows will work, but these come from experience rather than any attempt to anticipate events and her reactions to them. This situational approach to learning to function as a student nurse is consistent with the behaviour of the medical students in Becker et al's (1961) work. The dictates of the situation and meeting of the day to day requirements are the real priorities of the student's world. In the words of Becker et al (1961:442):

'He adapts his behaviour to the situation as he sees it, ignoring possible lines of action which seem pre-ordained to fail or unworkable, discarding those which may cause conflict - in short, choosing the action which seems reasonable and expedient'.

The main transition then, that the student must make on becoming a staff nurse, is from the position of a worker undertaking tasks allocated to her to the position of a qualified member of staff, allocating the work. It has been suggested that the ward sister adopts a bureaucratic rather than a professional solution to her problem of supervision of unqualified and untrained staff. The student has had the opportunity to see this style of management in action but has not practised it herself. There is a tension between two models of nursing organisation: the college taught, individualised care based on professional judgement model and the bureaucratic, 'running the ward' model. This tension is resolved, in practice at least, in a fairly arbitrary way. That is to say, the students learn from the college the rhetoric of individualised care and the bases for professional judgement, yet they soon discover that this does not work on the wards, where the sister commonly adopts a 'bureaucratic' approach in order to achieve her ends in patient care. The students found that the individualised care approach was inappropriate on the wards and adapted to the ways in which the qualified staff organised the nursing, invariably by routines. The students soon reached a point where they were prepared to justify the discrepancy between what they were taught and what they saw; the justification was made on the basis of expediency in the face of shortages of staff and time.

There are difficulties with the bureaucratic solution to the supervision of work which lie in the de-skilling of the work. These

difficulties arise with the question of professional socialisation, in terms of the students learning to apply their knowledge in order to make 'professional judgements'. It has been argued that trained staff solve the problem of having to achieve nursing work through unqualified and untrained workers, by resorting to splitting up the nursing work into tasks which results in nursing by routines. Also, it has been suggested that the students have some notion of how to function as staff nurses because they have observed staff nurses at work. The students do not, however, get a chance to see how the college-based notion of professional judgement is translated into the bureaucratic organisation of care on the ward. In other words, where the ward sister determined the patients' care, on the basis of her professional judgement, and then translates the overall plan into a set of routines to be undertaken by the students and auxiliaries, the students can only observe the resultant bureaucratic model. The professional judgement was an invisible process which the sister used to produce her plans for the care of the patients. There is, of course, a possibility that not all sisters go through the professional judgement stage when using bureaucratic approach to supervision.

The newly qualified staff nurse, it is suggested, organises the work on the basis of 'routines', which she has learnt as a student. On the face of it two approaches which the staff nurse might take to 'getting the work done' might appear to be the same. In the first, if she simply supervises the carrying out of routines, which she has seen tried and tested, then conceptually her work is not so very different from that which she undertook as a student. However,

taking the second approach, if she works from first principles, and applies her theoretical knowledge, acquired as a student, and arrives at decisions about patient care she can be said to be using her professional judgement. These decisions may then be carried out in a bureaucratic way, via routines. The data tend to suggest that the students regard the 'theoretical' input from the college as irrelevant on the wards; this would render the 'first principles' approach to nursing an unlikely option. In practice, it is not so easy to separate the notions of a routine 'bureaucratic' approach and a 'professional' approach to nursing. Indeed, the two concepts are interrelated because of the organisational context in which nursing is carried out. The 'professional judgement' approach, it could be argued, is more a question of degree. The ward sister might use her professional judgement and then achieve the work along bureaucratic lines. Alternatively, and the data would suggest this rarely happens, the sister might also allow professional judgements to be made by her staff. The question is then, perhaps not so much of 'professional judgement' versus 'bureaucratic' modes, but, the extent to which professional judgement is employed and by whom. In order to operate along entirely professional lines the nursing staff would have to be firstly, qualified, and secondly, experienced. As this is not the case the 'bureaucratic' approach enables the work to be achieved with a less qualified workforce.

The approaches have been juxtaposed in order to point up the fact that when the bureaucratic solution is adopted there is an assumption that the 'manager' is working on the basis of professional judgement. It is this assumption which is being questioned here. A newly

qualified staff nurse has not had the opportunity of practice nor the experience; she cannot, therefore, transfer her working premise from routine to professional judgement overnight. There is, then, a possibility that this transition might never actually occur; in which case nursing would be practised on the basis of tried and tested routines handed down from the days of their formulation, when the ward sisters were women of long standing experience. If this is the case the three years spent in training can almost be seen in terms of the student working her way up from the ranks, in order that she might assume command when she has put in the requisite number of years and achieved registration. This, it could be argued, is an expensive use of personnel. An analogy with the armed forces is not out of place in a discussion of the nursing service. The army recruits its leaders, by and large, from a different population from the one providing recruits to the ranks. Nursing, it seems, uses its future 'officers', along with auxiliary staff, to carry out a large volume of nursing work. The question of employment of auxiliaries versus the employment of students is addressed in the next section.

The questions raised here concerning the preparation of the staff nurse for her role, have to do with the structure and content of the training. The emphasis which the students themselves placed upon 'fitting in' and 'getting through' demonstrates the fact that the three years are seen in terms of short spells in different clinical areas; the students are constantly aware of their next move. This approach to their student experiences is consistent with the little value which is ascribed to the 'theoretical' content of training. This is a process which is rather different from one which allows anticipatory

socialisation to occur. For anticipatory socialisation to occur the students would need to spend longer periods of time in one place and to take more responsibility than is at present the case; in this way their work would more closely resemble that of the staff nurse. (1) Indeed, it is almost the opposite state of affairs in that the students become used to being highly mobile and taking little responsibility; they are then faced with settling down in one ward and having to play a part in 'running it'.

... and after registration?

Although these data were gathered from student nurses and are in the main concerned with the students' world, some discussion of the staff nurses' work is appropriate. It is mostly beyond the scope of these data to do little more than speculate about the consequences of becoming qualified; however, as the students made several references to the nature of work after registration, it seems apposite to make some comment.

The two main observations which the students made about the work of staff nurses were: first, that the staff nurses' work involved, very often, a move away from patients and secondly, that the staff nurse was still required to 'fit in'. The data suggest that the students did not wish to move into the ranks of the qualified staff, largely because they equated this move with one away from the patients. They acknowledged that there was probably some element of choice involved,

(1) Events have overtaken this study and the proposals for a new curriculum include longer spells of time for each clinical experience. cf. Schemes for Training for the Register of Nurses, General Nursing Council for Scotland 1978.

and that it might be that the staff nurses actually preferred less patient contact. Nevertheless, the idea that they might adopt a similar approach to nursing upon registration disturbed a number of the students.

These two comments upon staff nurse work are of interest as they represent both continuities and discontinuities with the student experience. The students felt that as staff nurses they would be required to move away from patients and undertake work which was different and more administratively oriented than the student work to which they were accustomed. However, there were also seen to be continuities with the work insofar as the staff nurses were, according to some of the students, still required to 'fit in'.

It is unlikely that many of the students entered nursing in order to obtain a professional qualification which they regarded as a ticket to professional functional autonomy. These data do not suggest that the students had independent nursing practice, in professionalising terms, in mind when they embarked upon their training. What they did appear to expect, after some time as a student nurse, was some degree of freedom in their practice. Yet the newly qualified staff nurse finds that she is working in a strictly bureaucratic organisation and having to continue to 'fit in' as she did during her three years as a student nurse.

This question of the professional within a bureaucracy is, of course, by no means unique to nursing. The role of a professional within an organisation has been studied many times by sociologists. It has been suggested that even the traditional professions of law and medicine lose some autonomy in favour of organisational rules by

virtue of being employed by organisations (Scott 1966). In the everyday sense, however, the professional retains a good deal of professional autonomy even though the organisation regulates the conditions of his practice in some way (cf. Dingwall and Lewis). Dingwall and Lewis describe the Janus character of a professional when one face is directed toward private individual client transactions and the other to the society which confers their monopolistic licence. This ambivalence, they argue, reflects the semi-autonomous position of the professions in relation to the state.

'The individualised model of service has organisational implications. The preferred form is collegial in nature, based on loose federations of practitioners in their own right. Such a model enshrines each professional's individualised discretion and equal competence ... The principle of professional autonomy encourages the view that, if the recipient of a personal service is unable to monitor its quality, that quality is guaranteed by the conscience of the providing doctor'. (Dingwall and Lewis, in press).

For the purposes of this discussion the wider questions of the professional within the organisation need not concern us. It is the hierarchical order in the nursing structure and 'the staff nurses' position within it which is of concern here. Qualified staff nurses find themselves working under the control of the ward sister. This arrangement has been discussed in relation to the supervision of nursing work. The professional or collegiate approach to supervision, it might be argued, is appropriate where qualified staff are working alongside each other. Yet, as the data have shown, it is more often the case that trained staff must supervise the work of the untrained and the unqualified. The means of achieving this supervision, commonly employed, is the 'bureaucratic model'. When the staff nurse and ward sister work together for the same spell of duty, according to

the students, the staff nurse still has to fit in. The problem to which the students referred in the case of staff nurses 'fitting in' with the sister has more to do with the specific issue of how qualified staff can best work together, than with the wider and different issue of the professional within the organisation.

Overall, it seems, that the student experience does not prepare the students for the work of a staff nurse. It does prepare them to pick up different ways of working and to 'fit in' with any given system of nursing and, importantly, to 'get the work done'. The original question - does three years of 'fitting in' prepare the student to be a qualified nurse - remains. There seems to be wide scope in the staff nurses' work which is dependent in part, upon what she makes of it and in part, upon how far the ward sister expects the staff nurse to 'fit in'. It must also be remembered that this discussion of the staff nurses' role is based on accounts of student nurses. Their future performance as registered nurses and indeed their views after registration could well differ from their present accounts. The students' accounts do, however, represent a defensible picture of ward organisation. It is argued here that so long as nursing care is carried out in an institution, where thirty or more patients are the responsibility of a small number of qualified staff, assisted by auxiliaries and students, a bureaucratic approach to care is defensible, and possibly inevitable. What is in question is the degree of freedom of practice which is possible within such a system. The ward sister has some degree of freedom in her managerial style (cf. Pembrey 1978); the staff nurses' position is determined by the

sister's attitude towards delegation. She may either treat the staff nurse as another student, who happens to be legally qualified to take over in the sister's absence, in which case 'fitting in' will characterise the staff nurses' behaviour. Alternatively, the sister may recognise the staff nurse as a colleague, albeit a less experienced one, and work with her on a collegial basis.

2. STUDENTS AND AUXILIARIES

This section is concerned with the idea that the students and auxiliaries are interchangeable as members of the nursing workforce. The important part which the auxiliaries play in the students' life has been a recurrent theme of this study (cf. Chapters 5 and 9). The notion of interchangeability of students and auxiliaries raises important issues about the idea of professionalising nursing. There is a school of thought which argues that nursing auxiliaries should not be referred to as 'nurses', because they are not qualified members of that occupational group. (1) However, these data, supported by others (cf. Baker 1978, Hardie 1980) suggest that nursing auxiliaries are, indeed, doing nursing. It seems, therefore, unhelpful to argue along nominalist lines of 'these are nurses, they do the nursing, these are not nurses ergo their work is not nursing work'.

Nursing work could be better described as work done for and to patients. If this approach is taken then it is possible to look at the different aspects of the 'patient work' and decide who might best carry

1. Interesting to note also, that the Royal College of Nursing will not accept nursing auxiliaries as members whilst student nurses may join

it out, rather than call it nursing work and look to a nurse to do it. Hughes (1971:312-313) says, in a discussion of 'nurses' work':

'Some may think that nurses are a bit presumptuous in daring to describe everybody else's work in order to learn what is their own. But that is the only way to do it well ... an occupation or a job consists of a bundle of several tasks. The thing that holds them together is that they are all done by one person and under a single name. A person, a name and a bundle of tasks ... Why are the tasks in this bundle done by the person who is called a nurse? For not all the tasks in the bundle require the same degree of skill'.

At the extremes of 'patient work' are the complex technical aspects of care introduced by the advances of medical technology and the less tangible psycho-social aspects of care. The former, it is not denied, must be carried out by trained personnel, whether 'nurse' training is appropriate or desirable for these aspects of care is another matter. Technological advances in medicine bring with them new breeds of technicians, this has already been seen in the form of anaesthetist technicians in operating theatres. The psycho-social aspects of patient care, it is increasingly claimed, must be undertaken by educated nurses. However, it is the case that there is a wide range of work undertaken in the name of 'nursing' and much of this is undertaken by nursing auxiliaries (Johnson 1978); it is to this issue which we now turn.

Interchangeability - students and auxiliaries

It has been argued that, in many respects, the student nurses and the auxiliaries are interchangeable as members of the work-force. Indeed, in some cases the students felt that the trained staff held the auxiliaries in higher esteem than they did the student nurses. The

auxiliaries are a stable element of the ward workforce, they know the ward well, have no formal training needs and are, therefore, often more efficient and less demanding of the trained staff than are the students. Also, the auxiliary is one of the key figures in the students' occupational socialisation. The students freely admitted that on entering a new ward they would seek advice from the auxiliary in their attempt to 'fit in' and 'get through'. Hardie (1978) supports this thesis:

'Because of ward assignment policies and other factors such as age and permanent local residence, auxiliaries are more likely to be a very stable element in the nursing team. This was acknowledged by nursing administrators and by auxiliaries themselves, both as a source of support to the head nurses and student nurses, and as a source of conflict. The head nurse has over time knowledge of the capabilities that a particular nursing auxiliary can undertake and may rely heavily on her. Student nurses, especially in the first week or two in a new environment, may be taught their duties and procedures by an auxiliary. Nevertheless ... the auxiliary remains at the bottom of the hierarchy and can foresee no change' (in Hardie and Hockey 1978:48).

The interchangeability of nursing auxiliaries and student nurses has implications for both the cost of the nursing service and the future development of the profession. It is the latter which is of concern here; it is, however, interesting to note in passing the economic question raised. The question becomes all the more important when the turnover rate of qualified staff is considered.

Mercer (1979) has shown that newly qualified nurses are a highly mobile population. They are, however, mobile within the service. About one quarter of nurses contribute to the annual 'turnover', that is move into, between or out of positions in the health service, each year. He sums up the trained nurse 'turnover' pattern thus:

'The mobility of trained nurses assumes a distinguishable profile: little is across occupations or between employers (i.e. beyond the N.H.S.) and mobility between regions is only moderately evident. Instead nurse turnover is essentially 'inter-firm' or 'in and out of work' (Mercer 1979:89).

Hardie (in Hardie and Hockey 1978:50) suggests that the major trade off in nursing employment appears to be between qualified staff and auxiliaries. "Where there are few registered nurses, there are many nursing auxiliaries and vice versa". It is not entirely clear what the implications of this employment pattern are, but, coupled with the interchangeability of the students and auxiliaries it could be seen as a warning light to ^{would} be 'professionalisers' and a possible attraction to planners and policy makers. Hardie (1980:229) found that:

'The extent to which any given health district is able to rely upon the use of learner labour as an employment strategy would appear to be the strongest determinant of the number of auxiliaries who will also be required'.

Hockey (1978), in putting the economic argument in connection with the employment of auxiliaries, said that it was the "responsibility of the nursing profession to define the danger zone, that is the prerogative of qualified nursing work". In this way nursing managers could know what ratio of qualified to unqualified staff they should have. Thus, Hockey urges for a professional basis rather than an economic basis for the decisions regarding employment. In her words, "The professional must be able to identify the professional result of substitution"(Hardie and Hockey 1978:64). We are still left with the question, how does nursing decide what is the 'danger zone'.

It is argued here that much 'nursing work' is carried out by

unqualified staff. At present students not only do much of the same work as auxiliaries but often learn how to do it from auxiliaries. Maybe what is required is more auxiliary nurses, being supervised along 'scientific management' principles with the planning being separated from the delivery of care, in all but the complex technical areas of work. The 'scientific managers' would require rather more in terms of preparation than simply spending three years as a worker and then 'getting to be in charge'. At present, the division of labour between trained and untrained staff, it is maintained, is obscured by the presence of student nurses. Following Hardie (1980), if nursing auxiliaries are not being employed and students are not available, then the only option is to employ qualified staff. The question raised here, then, is how far can nursing insist that the 'nursing' work must be done by 'professionals'. In other words is Hockey's 'danger zone' a question of patient safety or professional imperialism? It might also be argued that the employment of student nurses, because of their pre-professional status, and ongoing education, whilst still not qualified nurses, furnish the work-force with a 'professional' image which the nursing auxiliaries do not. In this respect, students and auxiliaries are not interchangeable.

The question of profession

It has been suggested already that if nursing is to make claims to professional status, these claims are somewhat weakened by the presence of large numbers of nursing auxiliaries who are 'doing nursing'. There is, it is contended here, a tension for the students. They experience on the one hand a convergence between their work and that of the

auxiliaries; yet, on the other, there is a divergence as the professionalising lobby, supported, in part, by the nurse educators, encourages the students away from the idea that their work is interchangeable with that of the nursing auxiliaries.

Johnson (1978) suggests that the 'dirty work' of nursing is done, by and large, by students and auxiliaries. This situation he maintains is handled differently by the two groups concerned. The students can leave or regard their place in the hierarchy as a temporary one from which they will eventually emerge to supervise other workers who will do the 'dirty work'. The auxiliary does not have this option, she must either leave or stay. The alternatives in the way of female employment may force her to do the latter.

'Her (the auxiliary) position as a hired hand at the bottom of the pile in nursing is the one which offers least in the way of status and improved monetary rewards' (in Hardie and Hockey 1978:113).

Just as the nurses were content to receive work which the doctors wished to cast off, such as blood pressure taking, laterly blood taking, measurement of central venous pressure, electrocardiogram reading and administration of intra-venous drugs; they are now engaging in a similar exercise with the auxiliaries. Medical work was welcomed by nurses because it represented special skills and responsibilities which allowed them to enjoy the reflected glory of the dominant profession. This 'prestigious' work assisted them, some would contend, in their professionalising efforts; others, with the researcher, would argue that the nurses only hope with such a venture was to achieve 'professionalism' (cf. Freidson 1970a).

This taking on work from above, in the hope of rising, and sloughing off work below is by no means a new phenomenon; Hughes in a discussion of "Social Role and the Division of Labour " said:

'The ranking has something to do with the relative clean-ness of the functions performed. The nurses, as they successfully rise to professional standing, are delegating the more lowly of their traditional tasks to aides and maids ... As medical technology develops and changes, particular tasks are constantly down-graded; that is, they are delegated by the physician to the nurse. The nurse in turn passes them on to the maid. But the occupations are being up-graded, within certain limits. The nurse moves up nearer to the doctor in techniques and devotes more of her time to supervision of other workers' (Hughes 1971:307).

The students in the study expressed interest in the technical aspects of their work; they placed greater importance on the medical knowledge rather than the 'nursing' they were taught, in short they succumbed to medical dominance. Such attitudes are consistent with the status claims described by Hughes.

'Professionalism', 'managerialism' and ...?

Nurses, it can be argued, may seek to enhance their status by taking on managerial tasks (Carpenter 1977) or technical tasks (Hughes 1971); Hughes also acknowledges that the nurses would have more time to devote to the managerial work of supervision. However, the main thrust of his argument has to do with the adoption of technical tasks by nurses. It is helpful in this discussion to conceive of 'technical' and 'managerial' tasks separately. Neither of these activities, it could be argued, constitute nursing work. The attraction which either avenue holds is that it does not fall into the realms of 'anyone could do it' work; work which could be carried out by nursing auxiliaries.

Carpenter (1977) describes the effects of the Salmon structure upon nursing in terms of what he calls the 'new managerialism' and 'new professionalism'. He argues that the Salmon reforms over-emphasised the managerial changes in nursing job descriptions to the detriment of clinical changes.

'It created a formal structure in which power, prestige and remuneration increase with distance from the point of patient contact' (in Stacey et al 1977:85).

Carpenter also says:

'Now nurses had absorbed many more complex managerial functions and the elite wished to relieve themselves of these routine tasks. There was an alliance between members of the elite, who found the routine tasks tiresome, and the state wishing to economise on skilled manpower and subject such jobs to productivity criteria. Once freed from these onerous tasks, the elite would be better placed to engage in higher planning functions and move closer towards parity with other elite groups' (in Stacey et al 1977:178).

As a reaction to this 'managerialism', Carpenter argues, the 'professional model' was revived by ward sisters, who showed an interest in developing clinical nursing. This clinical development, Carpenter suggests, is modelled on the American notion of the clinical nurse consultants, who 'cream off' the more complex parts of nursing. He also suggests that these clinical 'new professionals' might well push for the delegation of more routine functions of medicine. ⁽¹⁾ The formation of the Joint Board of Clinical Nursing Studies in 1970 and the subsequent proliferation of post-basic clinical courses for nurses formalised the position of clinical specialisms in nursing. The most important event for the 'new professionalism', as Carpenter terms it,

(1) cf. Habenstein and Christ's (1955) use of the term 'professionalizer' for those nurses who entrust low status tasks to auxiliaries and cling to the medically oriented work.

came in the form of the proposal of the Briggs Committee Report which sought to further separate educational from service needs. This move would mean something much more akin to student status for student nurses. Such a proposal would necessitate a large intake of nursing auxiliaries to replace the student labour.

The interrelationships between Carpenter's 'new professionalism', 'managerialism' and the Briggs' proposal's emphasis on student status are important in terms of the future development of nursing. If the aims of the 'new professionals' are to be realised then the general programme for nurse training must be improved. The Briggs' proposal, to this end, was to separate the students' educational requirements from the service needs of the hospital. Clearly, if the student labour were to be less amenable to service needs, then extra staff must be brought in; the grade of staff envisaged to fill the gap left by the students was, not surprisingly, the nursing auxiliary. The influx of auxiliaries leads to further considerations. Firstly, how is their work to be distinguished, if indeed it is, from nursing work and, secondly, the implications of increased trade unionism which came into the hospitals with the increase in nursing auxiliary numbers. The 'new professionalism' in combination with an increase in the number of auxiliaries, Carpenter suggested, would lead to a divide between 'clinical' and 'basic' nursing. 'Clinical', he uses in the clinical consultancy work sense, as developed in the United States, and 'basic', in the sense of nursing care which is not prescribed by doctors.

'Such a separation between "clinical" and "basic" nursing would represent a final break with traditional nursing values. No longer would the performance of basic nursing tasks be seen as noble and worthy in its own right, but as something to be performed only so long as it is necessary to learn how to do it' (Carpenter, in Stacey et al 1977:186).

The students' accounts of 'basic' nursing in this study were interesting; for on the one hand they would dismiss it as "not really nursing work" to be 'got through', whilst on the other, they were anxious not to be moved from the direct patient contact which they felt the trained staff lacked. Nevertheless, the general tenor of the data suggests that, at least some students, took Carpenter's line, they do it "only so long as necessary to learn".

Carpenter's analysis fails to take account of the fact that the nursing which he calls 'basic' is the area of nursing work which is the focus of those who are promoting nursing as an activity independent of medicine. 'Basic', therefore, should not be used in any perjorative sense, for it is the 'caring' core of nursing. McFarlane (1976) advocated the use of the word 'primary' in relation to nursing, in order to convey the meaning of the:

'the acts of helping and assisting individuals in activities they normally perform unaided, that are related to health. Primary nursing takes in both simple and complex acts'.

Clearly, this re-construction of 'basic' nursing refers to the independent aspects of nursing work which are important to those who seek to enhance the status of nursing.

It might be helpful to build upon Carpenter's notion of the 'new professionalism' and consider what might be called the academic approach to professionalising. The 'academic professionalisers', it could be argued, are promoting the autonomy of nursing through the elevation of the 'basic' nursing which Carpenter having distinguished it from 'clinical' work, relegates the former to the auxiliary and awards the latter to his 'new professionals'. The 'academic professionalisers'

refuse to classify the less technical aspects of nursing, which are independent of medicine, as either 'basic' or 'dirty work'. Rather, they seek to set the care, which McFarlane (1976) has called primary nursing, on a more academically respectable footing, via a logical problem-solving approach to nursing care, namely the nursing process. (1) Thus primary nursing has both an attendant literature and functional autonomy.

There does seem, then, to be a potential divide between those who would 'professionalise' and those who would 'unionise' nursing. 'Unionise' is a notion which must be treated with caution. Profession and union need not be mutually exclusive ideals, one has only to look at the B.M.A. and the R.C.N. with its recent ^{MOVES TOWARDS} T.U.C. affiliation. However, in the context of this discussion 'unionise' and 'professionalise' are used, following Carpenter (1977) in a broad sense in order to typify what he sees as the two major responses to 'new managerialism'. Professionalising has been discussed already and can be summed up as promoting nursing autonomy, and claiming professional, and therefore social, status. With respect to unionising Carpenter says:

'new managerialism has also led to the rapid growth of trade unionism among nurses. Emergent trade union consciousness was closely linked to the re-structuring

-
- (1) There is an ever-growing literature concerned with the nursing process. The process can cynically, but aptly and succinctly, be described as 'a schema for intelligent behaviour'. Kratz (1979:3) has a useful and more conventional definition; "(it) is basically a problem-solving approach to nursing that involves interaction with the patient, making decisions and carrying out nursing actions based on an assessment of an individual patient's situation. It is followed by an evaluation of the effectiveness of our actions".

of the labour force. Trade unions were swelled by the growing army of auxiliary and assistant nurses who, whatever their pre-dispositions, were excluded from professional organisations' (in Stacey et al 1977:187-188).

Dingwall (1977) in his introduction to Carpenter's paper states that:

'The extension of capitalist rationality to the health service has replaced a moral with a formal basis for elite legitimization. The interests of nursing leaders and the rank and file have increasingly diverged into a classical scheme of management and worker' (in Stacey et al 1977:163-164).

Carpenter states that along with the auxiliary-precipitated union involvement in the health service, there were large numbers of 'rank and file' (1) qualified nurses who have little ambition in terms of career and who, in Carpenter's words "became disenchanted by the careerist ethos of professional associations". The 'rank and file' qualified nurses who do not share the status ambitions either of their managerial or clinically oriented, 'new professional', colleagues merit some attention. Not least because these 'rank and file' nurses, described by Carpenter, appear to have much in common with the student nurses of this study. The students expressed a preference for medically oriented, technical nursing work. It is contended here that there is a third possibility in nursing for those who reject the managerial or clinical specialist alternatives; following Carpenter, this is described as the 'rank and file'. It is suggested that the

1. These nurses Carpenter says fit the "wage worker" model; ward sisters and staff nurses who do not consider themselves 'career minded' (cf. Briggs postal survey, paras. 526-529) cf. Habenstein and Christ's (1955) 'utilizers' are comparable 'wage worker' nurses

students in this study could be described as 'rank and file' nurses who take their status from doctor-oriented work, enjoy patient contact and a variety of nursing work. They are, moreover, not disturbed by a lack of autonomy and do not aspire to professional status claims beyond those relating to Freidson's (1970a) notion of 'professionalism'. Carpenter suggests that for 'rank and file' nurses:

'One of the attractive features of nursing as an occupation has been the variety of the workload. Advocates of clinical nurse consultancy seem to want to cream off the more complex parts of nursing, and deny the right of even the rank and file trained nurse to carry out a wide range of duties' (in Stacey et al 1977:189).

It was stated earlier that one way of nursing enhancing its status was to adopt technical aspects of care. It is contended that technical doctor-devolved work, which the students in this study enjoyed, is the type of nursing work favoured by the 'rank and file' nurses. The claim to status via 'professionalism' is one possible explanation of this; alternatively, it could be argued, that these nurses favour technical work in order to distinguish themselves from the auxiliaries.

Johnson (1978) explores yet another result of the managerial development in nursing from the auxiliary standpoint, in a discussion of deference (cf. Newby 1977). It has been argued in this section that the auxiliary and the student are interchangeable as part of the ward workforce. This notion of interchangeability can only be taken so far; for, although their work is ostensibly of the same nature, their positions differ in both status and time scale. The discussion of deference is offered in an attempt to point up this difference.

The main thesis of the deference work is that deferential behaviour does not necessarily represent a deferential attitude. Thus, 'real' deference only exists when the attitude and behaviour are deferential; for deferential behaviour without the same underlying attitude is calculative and, by definition, not deferential. The auxiliary is in a position where deference is required in most of her interactions. Johnson suggests that the auxiliaries' position stretches the rules of deference to their limit. He says that the auxiliary is given orders from above yet gets little support in her work, and can often be pushed beyond her true competence. Johnson sums up the auxiliaries' position in this divide:

'There seems to be great potential for calculative behaviour in the role of the nursing auxiliary, who has acquired skills and understanding through experience. In recent years she will have witnessed action amongst her trained colleagues which served to widen the gap between trained and untrained. But she too has become increasingly unionised ... The auxiliary, increasingly in the front line of nursing care, lives in a nursing world pre-occupied with education, research and management. She sees the occupation of which she is part moving away from sustained patient contact in pursuit of other, more status-oriented goals. Thus a rift is occurring between those who provide the front line patient care and those who control their work' (in Hardie and Hockey 1978:114).

It is this last point which Johnson suggests will strain the bonds of deference. The students in this study described the move away from patients which starts to happen in their final year; thus, Johnson's point about a widening gap can be taken. In the light of the students' accounts of their college education, and their pre-occupation with 'fitting in' on the wards, not least with auxiliaries; Johnson's comment about the world of education, research and management sounds a little removed from reality. The pre-occupation with management

would appear to be the most likely candidate for the auxiliary's attention. The student nurses are also aware of the line management in nursing, they commented commonly on there being too many managers, the nursing officer being the main target group to come in for criticism. However, as Johnson points out, the student nurses are on their way into the hierarchy, whereas the auxiliary is at the bottom with no prospects of rising.

Whilst Johnson's analysis of the auxiliaries' position is an interesting one the data of this study might throw into question his application of the 'deference' work to the auxiliaries' situation. The students found that the auxiliaries were significant figures on the ward both in terms of socialising agents and, at times, educators. The students also portrayed the auxiliaries as stable trusted members of the ward work-force on whom the sisters relied, both for work and, arguably, exercise of the social control required to preserve the 'ward way' of nursing in the face of a constant stream of transient student labour. Far from being deferent in either attitude or behaviour, it seems from the students' accounts, that the auxiliaries represent a self-assured, well integrated stable part of the permanent ward staff.

The student nurses, it seems, spend three years in a unique position in a divide between, on the one hand, the nurses, (cf. Hughes 1971) seeking 'professionalism', and the managerial elite who seek professional autonomy; and, on the other, the large body of unqualified nursing auxiliaries and the 'rank and file'. The student is in a position where she is exposed to the daily task of caring for patients, where her co-worker is often an auxiliary whose conditions of employment are protected through a trade union. She is also in the

process of becoming a qualified nurse, and thus exposed to the lobbies of professionalism and professional autonomy. The interests of this latter group can be protected in the name of 'professional association' which has connotations which elude the simple trade unions, whilst fulfilling a similar role.

The students in this study expressed a desire to stay and work with patients, rather than move away. Whether this represents the eagerness of youth, which will fade, or a 'rank and file' approach to nursing which requires a variety of work, and the status of profession, without the attendant casting off of 'basic' work, remains to be seen.

3. MEDICAL DOMINANCE

The third issue raised by a consideration of the categories is concerned with the dominant position of medicine among the occupational groups involved in health care. The students in the study expressed a preference for work in the more technical, fast-moving and medically dominated areas of nursing; in short, the technical doctor-devolved work preferred by the 'rank and file' nurses. It must be borne in mind that this preference might simply reflect the stage of their development, both as adults and nurses. Nevertheless, in the absence of contradictory evidence it is reasonable to accept the students' stated preference for the type of nursing which has medical connections and is thus regarded as prestigious work.

This preference highlights a potentially important tension between the academic professionalising element in nursing, which is pressing for more autonomy and independence of medicine; and, the mainstream rank and file of nursing which, it is contended here, might be content

with the reflected 'professionalism' which is gained from the close working relationship with the medical profession (Freidson 1970a). The area in which nursing is most likely to gain a foothold for independent practice is in the care of the long-term sick. This specialty has several attractions for the professionalising nurse. It is not overly popular with the doctors, there is not a great deal of diagnosis and treatment in a conventional medical sense. Care rather than cure, social as well as clinical well-being are the goals. This is not to suggest that the social well-being of the patient does not concern the medical staff in other specialties. It is simply the case that when cure becomes an impossible goal because of the multiple pathology and degenerative diseases of old age, the potential for improvement tends to lie in daily living and social activities. Much of this kind of work can be achieved by nurses making assessments, setting goals and working towards these in order to help the patient reach his full potential. This is part and parcel of the rhetoric of the 'academic professionalisers'. Yet, it is argued on the basis of this study that the students, whilst they expressed a surprised liking for geriatrics, by far the most favoured clinical area was the surgical ward, where there is likely to be more technical work.

It is not the intention here to argue the case for the professionalisers or those content to bask in professionalism. The point is simply that the student nurses in this study following Carpenter's (1977) 'rank and file' nurses, showed little interest in divorcing their work from medicine. They were, in fact, happy to describe certain aspects of patient care as 'doctor's business' for instance, telling the patient his diagnosis and prognosis, or giving

information about his condition. This willingness to subordinate nursing to medicine was not seen by the students to detract from nursing in any way.

The students were, by and large, content to consider that it was the doctor's place to decide what 'his patient' should be told about his condition, and act accordingly. Such subordination, it could be argued, is evidence of the student surrendering any claim to professional autonomy. Such an argument turns on the analyst's perspective on profession, whether he takes a 'trait', functionalist, approach or Becker's (1970) notion of a 'folk concept'. It could also be said, setting aside the finer details of analytic debate, that the view taken by the students was a realistic one. They recognise medical dominance for what it is and do not allow it to interfere with their conception of nursing. This realistic view is summed up by Freidson (1970a:76) who argued that the dominant position of medicine frustrates any efforts which the 'paraprofessionals' make towards securing full professional autonomy.

'It might be noted that paraprofessional occupations usually seek professional status by creating many of the same institutions as those which possess professional status. They develop a formal standard curriculum of training, hopefully at a university. They write codes of ethics. They are prone to seek support for licensing or registration so as to be able to exercise some control over who is allowed to do their work. But what they persistently fail to attain is full autonomy in formulating their training and licensing standards and in actually performing their work. Their autonomy is only partial, being second-hand and limited by a dominant profession'.

In a similar vein, but with respect to education, Katz (1969) states that:

'Much of the content of the modern nursing curriculum supplements physiology and anatomy with behavioural science items. This has doubtless added a measure of socio-cultural sophistication to innocent, undifferentiated T.L.C. (1) But nurses have not thereby achieved a distinct body of knowledge that has been accepted by their medical colleagues. In addition, the behavioural knowledge about her professionalism has done little to alter the nurses' subservience to the hospital physician. Behavioural scientists have not really proven that they are capable of aiding the ladies in their professional distress' (in Etzioni 1969:75).

The trappings of profession are present but the autonomy, it seems, is unattainable so long as the profession of medicine dominates.

One of the striking features of the students' accounts was their lack of concern to rid themselves of medical dominance; indeed they seemed rather to cling to it and take the medical position as their point of reference.

(1) Tender loving care.

'FITTING IN' TO NURSING?

The analysis of the students' accounts, which has been presented in the form of six conceptual categories, has tended to highlight some of the more negative aspects of the student experience. However, the ambiguities within the data help to redress the balance a little insofar as the students would be at one moment critical, yet, at the next, would either rationalise their position or make justificatory statements in defence of the organisation of their teaching. Thus, whilst the students voiced their difficulties on the wards and in the college, they were accepting of, and, on occasion, anxious to justify the status quo. It should also be said that the overriding impression gained from the students' accounts is one of a genuine motivation, on their part, to 'do a good job' and to help the patients in their care. Thus, it did not appear that the students felt that the difficulties they experienced so frustrated these immediate goals as to call for radical changes in the organisation of their education and training.

The students recognised that the college of nursing did not provide an altogether realistic preparation for work on the wards; moreover, they could not always see the relevance of nursing management to the care of patients. The students did have some conception of the workings of the line management structure. They acknowledged that the staff nurse's position required her to 'fit in' with the ward sister, who, in turn, was directly accountable to the nursing officer. Thus, the students accepted the fact that, once qualified, they still faced a diversity of influences which would impinge upon their work and hence upon the realisation of their prime goal, that is, to 'do a good job' for the patient. The reification of these diverse influences suggests

the existence of various groups within nursing, each with its own interests, a point which is consistent with the literature already discussed. In this last section, then, it is the intention to examine this question of diversity in the occupation which the students spend three years preparing to join.

For the purposes of this discussion Carpenter's (1977) work is drawn upon and extended so that four groups can be identified within nursing:

'new managers'

'new professionals'

'academic professionalisers'

'rank and file'.

Briefly these groups can be characterised thus. The 'new managers' emerged after the Salmon ⁽¹⁾ report recommendations. They operate according to an industrial model of professionalised management, their organisational structure takes the form of bureaucratic line management rather than a collegial model of professional behaviour. The 'new professionals' are, as yet, a very small group of clinical nurse specialists, ⁽²⁾ described by Carpenter as a result of a reaction to the 'new managerialism'. These clinical specialists, who are independent of line management, stand outside the hierarchical structure of nursing. The 'academic professionalisers' are to be found, in the main, in

-
1. Report of the Committee on Senior Nursing Staff Structure (1966)
(Chairman: Salmon, B)
 2. These are nurses with specialist knowledge and experience in a particular area of clinical practice; they act in an advisory capacity providing a clinical consultancy service for less experienced nurses in the field

academic circles, and might be seen to be removed from the patient settings. The work of this group centres mainly upon research and the teaching of undergraduate nurses. They seek to achieve autonomy for nursing by elevating the status of 'basic' or 'primary' care, and placing less emphasis upon medically prescribed work. In short, their aim is to promote a style of nursing founded on 'nursing theory', which can take its place among other academic writings, rather than nursing which is founded merely on tradition and medical dominance. The fourth group, the 'rank and file', can be regarded as the mainstream of nursing. These are the nurses who enjoy both the doctor-devolved work which they undertake and, the reflected 'professionalism', which comes from working closely with the medical profession.

Whilst the students in the study appeared mainly to identify with the 'rank and file', they were exposed to the influence of at least one of the other three groups, namely the 'new managers'. In their capacity as 'workers' the students are subject to the authority of the 'new managers'. It is also possible that the students came into contact with the 'new professionals' and, indirectly, with the 'academic professionalisers' through their education programme.

The following discussion is necessarily discursive, for, whilst its subject matter is rooted in the data, the debate moves beyond them. It is offered as a means of pointing to the wider issues which the study raises; these issues have to do with the occupational structure of nursing, and might repay further investigation. Much of the discussion in previous chapters has centred on what nursing is; here, this question is considered in the light of its interpretation by each of the four groups within nursing. It is suggested that while all four groups have

as their officially understood aim an underlying concern with the provision of health care, each has a rather different approach to nursing in terms of expectations and motivations. The implications of this diversity of approach need seriously to be considered. For, if nursing is to move forward as an occupational group with a solidarity which makes it a cohesive body, the question must be asked - "in whose interests are these various developments and in which direction should the occupation as a whole move?" Can these four groups be accommodated in a heterogeneous occupational group, or will there be a struggle for hegemony, which might not be in the best interests of either the patients or nursing.

Conflicting interests

The 'new managers', Carpenter (1977) suggests, seek to professionalise through their managerial work, which is based upon principles of business administration, rather than through their nursing skills. The development of this administrative work has resulted in the group becoming rather distanced from direct patient care. A further consequence of this distancing is that sight can be lost of the fact that the 'new managers' can only justify their existence in terms of their role in the facilitation of patient care. Compounding the situation even further, is the line management structure, which militates against a collegial approach to the work. The 'new managers' do, however, offer advantages to nursing, insofar as they represent nursing on committees, at all levels, in the health service. Whether this is beneficial to nursing is clearly contingent upon how well the 'new managers' are able to represent the 'coalface' view of the nurses who are in daily contact with patients.

The 'new professionals', described by Carpenter, are not discussed here in any great detail, as they constitute a small minority among nurses. It is possible that this group of clinical specialists might lead the way to a clinical rather than a managerial elite. If such clinical specialisms developed, it might, as it has been argued, be at the expense of the work satisfactions of the 'rank and file'.

In one sense the 'academic professionalisers' can be seen simply to coexist with the other three groups and not impinge a great deal upon their work. Although, it should be remembered that whilst the 'academic professionalisers' are not dependent upon the health service for funding, they are in the hands of the administration when it comes to finding clinical placements for their students. Thus, the relationship between the 'academic professionalisers' and the 'new managers' is an important one; and, the 'academic professionalisers', if they are not to become entirely removed from the clinical area, must bear this relationship in mind.

However, the 'academic professionalisers' efforts in the promotion of nursing autonomy and the development of 'nursing theory', might be seen to have possible implications for both the 'new managers' and the 'rank and file'; indeed, their activities present a potential threat to these two groups. In the case of the 'new managers', the challenge stems from the fact that this group, which Carpenter has dubbed 'the managerial elite', have sought to professionalise through the abandoning of those very skills of 'basic' nursing care, whose development the 'academic professionalisers' believe to be essential in the struggle for nursing to become an autonomous profession.

Hence, the professionalising power of the managers lies in their administrative skills, and any attempt at forming an academic elite, on the basis of 'primary nursing', would pose a serious threat to the 'new managers'. Indeed, such a development on the part of the 'academic professionalisers' would require so great a change in both the approach and the function of the 'managerial elite', as to undermine their power.

The 'rank and file' might be seen to be threatened by the 'academic professionalisers' for different reasons. The latter group could be said to have interests which are not in line with those of the former. The academic nurses are eager to promote those areas of patient care in which medicine need only play a small part, if indeed any, for example in the long term care of the elderly. These are the very areas in which large numbers of untrained staff, the nursing auxiliaries, work and are the areas which are not held in great esteem by the 'rank and file' nurses. For, as it has been argued, whilst the students in the study defended the work of auxiliaries, they also made certain claims of 'differentness' for their own work. The 'rank and file', it is suggested, would find this 'differentness' through their connections with medicine rather than through the 'academic professionalisers' reconstructed approach to the 'basic' aspect of nursing care. Furthermore, if, as it seems, in their moves to elevate 'basic' nursing care to a position of prestige, the 'academic professionalisers' are suggesting an alternative approach to this type of work, the 'rank and file' could be antagonised. For when the work which has always been carried out by the 'rank and file', or indeed by

the nursing auxiliaries, is suddenly questioned and approached in a different way ⁽¹⁾ by the 'academic professionalisers', then the 'rank and file' might feel both criticised and threatened.

Leaving aside the issues of any future conflict between the 'academic professionalisers' and the 'new managers' or the 'rank and file', it is instructive to examine the current line management approach to clinical nursing. This approach, it is argued here, is inappropriate, insofar as it confuses management of nurses, in a personnel work sense, and management of nursing, in a clinical sense. A prime example of the inadequacy of this approach can be seen in the relationship between the ward sister and the nursing officer. Officially, the nursing officer, through the managerial structure, has a responsibility for the management of clinical nursing. However, it would appear that the responsibility for this aspect of management rests with the ward sister; and she may well feel that she has no experienced colleague to whom she can turn to for clinical advice should she need it. According to the management structure she will be expected to consult her immediate superior, the nursing officer, who may well not have the relevant clinical experience, or has become more interested in managerial than clinical issues. Moreover, the ward sister's perception of the nursing officer as an experienced clinical colleague, may well be contaminated by their hierarchical relationship. A major facet of this relationship is the ward sister's certain knowledge that she will be formally assessed and appraised by her nursing officer. This line relationship could place limitations on

1. The 'nursing process' which lays emphasis upon the assessment and planning as well as the carrying out of care

the ward sister's willingness to request clinical advice, for such a request might be interpreted as a sign of incompetence by a superior. Thus there is little hope of advancement in a clinical career so long as nursing confuses advice with assessment and remains too far entrenched in a hierarchical managerial system, which militates against a collegial model for nursing. Such a model would uphold the notion of equality of competence and individual professional discretion among its members, who, whilst recognising the existence of senior and junior status, would complement each other's practice.

Towards a reconciliation of interests

The four groups which have been identified within the wider occupational group of nursing, it has been argued, have different interests in and expectations of nursing. Rather than dwell upon how these differences might be resolved, by the proselytising activities of the more powerful groups, or, indeed, by fiat; it is the intention here to examine how the groups might articulate with each other in their efforts to provide a nursing service. In discussing the possible ways in which these groups might co-exist, attention is given to the motives which might underly the approach of each group to nursing.

The 'new professionals' in conjunction with the 'academic professionalisers' might provide a basis of nursing knowledge which the 'rank and file' could incorporate in their own work. This would go some way towards meeting the ward sisters' need for clinical advice which they are often unable to obtain from their management oriented superiors. In this sense both the 'academic professionalisers' and

the 'new professionals' might be said to have more to offer the 'rank and file' than have the 'new managers'. It has already been argued that the line structure of nursing management is an inappropriate model for the management of patient care at ward level. It is possible, therefore, that the 'rank and file' might see that the clinical knowledge available to them from both the 'academic professionalisers' and the 'new professionals' is of practical use in their work. Such a development might pose a threat to the 'new managers' as the other two groups could be held in greater esteem by the 'rank and file' insofar as they represent specialists in nursing, rather than in administration.

Such co-operation between three of the groups leaves us with the 'new managers', who are, it must be remembered, at present a powerful group. A clinical alliance on the one hand, and a managerial elite on the other, is suggestive of some need for a stronger clinical input into the managerial structure of nursing. If the 'new professionals', who are largely clinical specialists, were to be drawn into the hierarchy rather than, as is the case at the present, remaining on the periphery, such a clinical strengthening could be achieved. In order to realise this clinical strength, the 'new professionals' would have to join the 'new managers' on clinical terms; that is on the terms of the 'new professionals'. This would, in effect, resemble the medical profession's managerial structure in that clinical expertise remains an important factor all the way up the hierarchy. If such a system of nurse management were implemented, the clinical aspects of the work might regain some of the ground which has been lost since Salmon, in favour of a managerial emphasis.

Beyond their function as providers of knowledge, as outlined above, the 'academic professionalisers', it would seem, have to make a case for their continued existence as part of nursing as a whole. If they hope to play a significant part in the workings of nursing, then their attitude towards the other three groups should be an important consideration. It has already been said that they might present a threat, on different counts, to both the 'rank and file' and the 'new managers'. It is perhaps pertinent here to consider the possible motives which might underlie the behaviour of the 'academic professionalisers'. It could be argued that this group obtain their satisfaction from the intellectual exercise of promoting nursing as an autonomous activity, which is based on academic theorising and is free of medical dominance. Whether or not this group would sustain their interest if they were to find themselves practising according to their reconstruction of 'basic' nursing, might be another matter. The question remains, whether this intellectual activity is undertaken for altruistic reasons concerning patient welfare, or whether it is a means of achieving academic elitism. This is probably a question more easily raised than answered.

The 'academic professionalisers' could be said to be in danger of fault-finding and producing critical reports of current practice without always providing viable alternatives. They can, as it was suggested above, also be accused of taking a position which is isolated from the mainstream of nursing activity and indulge more in 'armchair nursing' than in practical nursing. The future of 'academic professionalisers', it is argued, is in their own hands. So long as the group provides

insights into nursing practice, without destructively criticising the other groups, it should secure a future in the wider occupational group of nurses. Moreover, the products of academic nursing, both in terms of nurses and research findings, could be used to facilitate the work of the 'rank and file', 'new managers' and 'new professionals'.

Success of the 'academic professionalisers' in setting 'basic' nursing upon a new foundation, would inevitably have implications for the other groups, and for nursing education. The new foundations involve the notion that nurses should be able to prescribe, plan and assess care in relation to patient needs, in those areas of health care which do not demand medical involvement. Remembering the limitations of the bureaucratic solution to the supervision of nursing, it could be argued that the 'academic professionalisers' along with the 'new professionals' might develop a style of nursing based on 'theory' and, thereby, go some way towards producing a 'scientific manager' (1) type of ward sister. These nurses would have been taught nursing skills first and foremost with the medically dependent work taking second place in their prestige rating. As it has been discussed, one of the problems of the transition from student to staff nurse, was the management of nursing care and the exercise of professional judgement. It is suggested, therefore, that nursing might benefit if the education of nurses proceeded along the lines suggested above and

1. The concept of 'scientific management' is discussed in Chapter 5

nursing concentrate upon the production of a small number of these nurses, who would become the 'scientific manager' ward sisters; rather than, as is currently the case, producing large numbers of nurses, many of whom function at a lower level than the one proposed here.

Such a solution would provide among the 'rank and file', clinically competent ward sisters who would have no objection to obtaining help from the clinically oriented 'new professionals' or the 'academic professionalisers'. At the same time it would provide the 'academic professionalisers' with the opportunity to facilitate the work of the 'rank and file'. Whilst this arrangement would produce the possibility for complementary work to take place, it would, once more, alienate the 'new managers'. There seem to be at least two alternatives here. On the one hand, the 'new managers' might work in close conjunction with the 'new professionals', and allow this latter group of clinical specialists into the power structure. Together these would clearly form an important group. If, on the other hand, the 'new managers' had only managerial elitist interests, and showed little interest in clinical involvements, there could be a strong case made for managing nurses through a personnel department, with a professionalised managerial approach. This need not include nurses at all. Either of these alternatives, it seems, would undermine the power of the 'new managers' as a single group. This is largely inevitable, because, not only are the 'new managers' at present the most powerful of the four groups discussed here, but the suggestions for change demand a move away from their managerial/elitist activities towards the more commonplace ones of clinical nursing. Also, if, as it

has been suggested, the 'rank and file' is allowed, through its association with the 'academic professionalisers', a stronger voice in nursing care, this group might pay less heed to the 'new managers' whenever it can.

The influence of the work of the 'academic professionalisers' on nursing education could focus on the production of 'scientific managers', as outlined above. These 'scientific manager' sisters could then supervise the work of a less skilled, possibly unqualified, staff. The 'rank and file' would then comprise the wide range of talent which it does at present, the difference would lie in the fact that this characteristic of the 'rank and file' would be recognised. Nurses could then be differentially trained to do a sufficient range of work, which would enable the 'scientific manager' styled supervisors, the ward sisters, to delegate planned work to a workforce with a suitable functional capacity. In this way the 'scientific management' approach to a bureaucratic supervision of nursing work could occur without training all the 'rank and file' beyond their required functional level. ⁽¹⁾ At the same time the ward sisters could be provided with a more adequate education in preparation for managing nursing, than the three years of 'fitting in' described by the students in this study.

Nursing, it would seem, stands in need of a flexible structure which would allow for the continuance of a variety of interests within the occupation. Having looked at some of the possible directions in

1. The data pertaining to the interchangeability of student nurses and auxiliaries is relevant here

which the different groups within nursing might choose to take an occupational lead, we return to the student nurses' accounts of their work and training. These students expressed a positive liking for patient contact, albeit difficult at times, for reasons which have been discussed. They also suggested that the pace of the work and their connections with medicine were sources of satisfaction for them. Finally, although there was little direct discussion of 'profession' as it is understood by sociologists, they gave a distinct impression that they considered nursing to be an occupation which was 'different' from many, and, one which carried with it social value.

The student nurses were aware of the fact that one of their prime activities throughout their three years training was that of 'fitting in'. They also accepted the fact that they placed little emphasis upon college work and instead concentrated on the 'ward way' of nursing. All in all, this did not seem to them to add up to a negative experience. They accepted that much of the difficulty of nurse training was inevitable and continued to 'fit in' and 'get through'.

These students, it has been suggested, identify most closely with the largest of the four groups in nursing, namely the 'rank and file'. The way in which these and other nurses of the 'rank and file' proceed in their nursing work could be said to influence the future of patient care, from the patients' perspective, more than the activities of the other three groups, with the possible exception of the 'new managers' as this group is both a powerful and well established entity. Much of the professionalising rhetoric and academic aspirations appear to have more

to do with internal occupational development than with the service which nursing provides. It is, of course, true to say that these factors are not unrelated; but for some considerable time to come the patients will see nursing as it is presented to them through the 'rank and file'. The existence of the other groups can, then, only be justified insofar as they enable the 'rank and file' to provide as good a nursing service as is possible. To this end, the 'new managers' with their representation on health service committees should ensure that the means for effective patient care are available to the nurses working in the patient areas. The 'new professionals' role in the facilitation of patient care is not at the present time immediately apparent, although some progress towards clinical excellence should be mediated by these specialist nurses. Their future would probably hold the most promise if they can take their clinical strength into the managerial structure. The 'academic professionalisers' should provide all three groups with research findings and theoretical insights into the practice of nursing.

It has been argued that whilst they are all ostensibly concerned with health care, the four different groups have different approaches to and interpretations of nursing. Broadly, a distinction can be made between a convergent approach to nursing, as exemplified by the 'rank and file' and a divergent approach which the 'academic professionalisers' could be said to adopt. The convergent approach shows no interest in breaking away from medicine in order to develop an autonomous profession. This approach could be seen to be congruent with the current trends of teamwork and a multidisciplinary approach to health care. Whereas the

divergent approach seeks to develop nursing as distinct from medicine, and in that respect runs contra to current trends.

Where an occupational group so diverse as nursing has to put forward a united front to the outside world, whilst riding and reconciling its own internal differences, the choice between convergence and divergence is a difficult one. It is, however, worth noting that the convergent approach should only be adopted with some caution.

For, whilst the profession of medicine remains dominant its interests will triumph; and it is by no means certain that the interests of the medical profession coincide with those of the patient. Nursing could, and the researcher would argue should, play a role in protecting the patient from the excesses of medical dominance.

Although, it must be said that the development of an autonomous nursing profession might be as detrimental to the patient interest as it has been suggested medical dominance is. Professional advancement and patient interest are not easily reconciled, whichever professional group is involved. The 'rank and file' nurses might mediate in this potential difficulty by virtue of their willing acceptance of medical involvement in nursing.

On the basis of these students' accounts, it is suggested that the occupational group, which operates under the name 'nursing', must accept that there exists within it a wide range of interests, skills and academic ability, if it is to continue as one group. Much of the difficulty in defining what nursing is, both in terms of activity and professional status, lies in the heterogeneity of the group. The recognition of the abilities and limitations, and of the expectations and motivations of the different factions within the totality of nursing

would seem to provide some hope for the survival both of nursing as a united occupational group, and of its officially understood aim - the promotion of health care. Its future will, to a large extent, also be dependent upon the changes both within the medical profession and society as a whole. Change in the age structure, disease patterns, population trends, economic and social constraints which result in less emphasis on the technological and more on the human aspects of care will, in all probability, lead to nursing coming into the forefront of health care. In this event, there must exist a united nursing body, which will not only be able to represent the needs of the nursing service at government level, but will also be able to provide care of various complexity, requiring different levels of skill, safely and efficiently.

The realisation of a united occupational group is contingent upon the ability of the four sub-groups to articulate with each other in order to produce, and reproduce, an efficient nursing service. This thesis has been concerned with the students' construction of their encounters with the occupational group which undertakes work recognised as 'nursing'. The students described how they 'fitted in', throughout their training, both on the wards and in the college. This pattern of behaviour, they recognised, was a short-lived necessity during their student days. As they approached registration they expressed anxieties about joining the qualified nurses. This was partly because they perceived staff nurse work to be intrinsically different from their student work, but also because they realised that they would have to continue to 'fit in', this time, in a more enduring sense, into some part of the occupational group, 'nursing'. Paradoxically, the

students, having spent three years 'getting through' their student days, had reservations about becoming staff nurses. There is a subtle distinction to be drawn here: the students' aim was perhaps simply to stop being students, rather than to become staff nurses. In the light of the above discussion of the four groups within nursing, it is contended that the students' apprehension is understandable, once it is recognised that nursing is not simply one occupational group, but a group of groups. The complexities involved in the occupational structure, along with the experiences described in this thesis, might go some way towards explaining the students' reservations about becoming registered nurses. Although they were referring to the medical profession, the words of Bucher and Strauss neatly sum up the position of nursing today:

'the assumption of relative homogeneity within the profession is not entirely useful: there are many identities, many values and many interests'
(Bucher and Strauss 1961).

ENDNOTE ON METHOD

Grounded theory revisited

This thesis was influenced by the work of Glaser and Strauss (1967) and has benefited largely because of the flexibility which their approach offers. The notion of generating 'grounded theory' was problematic from time to time during the fieldwork. The difficulty arose when the researcher became overawed by the feeling that the production of one 'substantive grounded theory' should be the end point of the study. However, it became apparent as the work progressed that the key to the analysis lay in the explanatory power of the conceptual categories. When the links between these categories were made explicit an overall picture of the student nurses' world became clear. This thesis has, then, attempted to present an analysis of the students' accounts of their world by explicating the themes of the data via conceptual categories. The concept of 'fitting in' offers probably the most succinct analytic means of presenting the essence of the students' world.

In retrospect, the researcher views the work of Glaser and Strauss in a different light; that is with an emphasis on the spirit rather than the letter of grounded theory generation. Their description of the procedures for generating theory, which at times tended to confuse rather than clarify, left the researcher with a sense of having fallen short of their ideals. However, their definition of theory bears repetition as it offers some hope and leaves the analytic methods of this study not too far removed from the position taken by Glaser and Strauss. They define theory in sociology as:

'a strategy for handling data in research, providing modes of conceptualisation for describing and explaining'.
(Glaser and Strauss 1967:3)

Thus, whilst this study arrives at no theory which can be stated in a concise way, the conceptual categories are offered as a means of describing and explaining the student nurses' accounts of their work and training.

The fieldwork method employed in this study, it is contended, has had some success in eliciting the students' views of nursing. The informal and flexible approach, loosely based on the idea of 'grounded theory' generation, allowed the students to raise topics which the researcher would not have thought to include in any more structured research design. This study, then, has contributed to our knowledge of the student nurses' perspective on nursing. At the time of writing the structure of nursing, and the organisation of its education, is on the brink of change. ⁽¹⁾ It is suggested that it would behove the planners to take cognisance of the insights into nursing, such as those offered by this study, especially at a time of organisational change. The student voice is a weak one, but, it should be remembered, it represents a major element of today's nursing workforce and, importantly, tomorrow's qualified nursing service.

1. Implementation of the Nurses, Midwives and Health Visitors Act 1979 is underway

APPENDIX I

Extract from 'Patterns of Ward Organisation'

Extract from Moulton, Hockey and Melia (1978) 'Patterns of Ward Organisation' (pp. 129-130). (1)

This study set out to determine whether nurses talk with patients outside the context of direct care. It was hypothesised that, nurses do not talk with patients unless they are involved in some physical aspect of their care, and that nurse-patient conversation per se would be more prevalent in a 'patient orientation' system of organisation.

The first hypothesis was confirmed. The findings suggest that little nurse-patient conversation takes place at all at times other than when the nurse is undertaking some direct care activity. The time spent in talking with patients was found to be limited to such a degree that 'conversation' is hardly the pertinent term. The second hypothesis was neither confirmed nor refuted.

There was marginally more nurse-patient conversation, occurring, without any accompanying nursing activity, within the "patient orientation" system of ward organisation, than in the "task orientation" system. It has already been suggested that there could be a combination of factors contributing to the greater amount of communication in the "patient orientation" system.

The multiple regression analysis did not produce any significant linear combination of 'predictor' variables for the dependent variable of time spent in conversation. This analysis did however

(1) This extract is from the discussion of the researcher's observational study of student nurse - patient communication.

suggest that the "patient orientation" system of ward organisation and "elderly" patients were variables which bore some relationship to the total time that nurses spent giving direct care to patients. The possible connection between "patient orientation" system of ward organisation and the total time the patient spent with the nurse is supported within the limits of this investigation.

The main finding of this study was that the average length of a nurse-patient conversation which was not linked with another nursing activity was 45 seconds. If, as the researcher contends, communication between nurse and patient is an essential part of nursing it would seem that this study has shown the need for improvement in the area of nurse-patient communications.

APPENDIX II

An outline of student nurse training

Outline of student nurse training

This description of nurse training is included in order to provide the reader with an idea of the organisation of nurse training. As each college of nursing has a certain amount of freedom within general national guidelines, this outline does not pretend to reflect any specific training programme.

The students typically start with an 'Introductory Block' of about eight weeks, during which time they attend lectures in the college and are introduced to the hospital. This is followed by periods of time, eight to twelve weeks, spent nursing in different clinical specialties including: medical, surgical, paediatric, operating theatre, community care and psychiatric experience. The students can spend time on more than one ward during a particular experience, which means that whilst the placement might be, say, 'surgical', they could go to two separate wards and spend perhaps four or six weeks on each.

There are further, usually three, 'Blocks' of time spent in college at intervals through the training. After approximately six months the students sit the 'Bar Examination'; this is a state examination which they may resit once and failure to pass prevents the student from continuing with training. After two and a half years the students sit their State Final Examinations, the remaining six months, the pre-registration phase, is a time for consolidation and preparation for registration.

Satisfactory clinical progress must be maintained throughout the three years, and, before the student's name is put forward for registration the Director of Nurse Education must certify that clinical

proficiency has been achieved. The nature of the students' clinical progress is evidenced by their reports, which are made, generally speaking, by the sister on each ward. Thus, in order to become registered nurses the students must satisfy the college of nursing in both their written and practical work.

APPENDIX III

Publication

Student nurses' construction of nursing

A discussion of a qualitative method

A group of student nurses were asked to say what they thought was important in nursing. The results of this research reveal that more time could be spent actually talking to patients

Kath M. Melia, B. Nurs (Manc), SRN, HV, NDN Cert

THIS PAPER is concerned with a methodological approach to the question of 'how do student nurses view nursing?' The following discussion is, therefore, twofold, first the substantive area in question is considered and secondly, the research method employed is discussed.

The study arose out of an interest in discovering what student nurses thought were the important aspects of nursing. This interest itself was a progression from a concern with the amount of time that nurses spent talking with patients. The researcher had been involved in an observational study which attempted to relate style of ward organisation to the amount of time that student nurses spent talking with patients. (Moult, Hockey and Melia, 1978).

Talking

One of the main findings of the above study was that whatever the organisational style of the ward, the nurses spent very little time simply talking with their patients. It must be borne in mind that these findings were based on a small number of observations and that the researcher was only recording those occasions where nurses spoke to patients outside the context of any other nursing activity. It was with these findings in mind that the researcher became interested in discovering more about what the student nurses thought of nursing and, indirectly, if communication with patients would be raised as an important part of nursing.



... the researcher became interested in discovering more about what the student nurses thought of nursing and, indirectly, if communication with patients would be raised as an important part of nursing

The study of student nurses

The underlying premise of the present study is that nurses' actions, particularly student nurses' actions cannot be taken at face value. There are other factors, social contextual factors in operation which might affect what a nurse does. It seemed a logical progression, therefore, to move from observation of the students to a research method which allowed some insight into their construction of nursing. This raises the second and important issue of this paper, that of finding an appropriate method by which to study students' views on nursing.

The method employed is briefly described here in order that the more general discussion of the case for qualitative methods in nursing research might be illustrated. The method chosen was that of informal interviews which the researcher tape-recorded and later transcribed. There was no formal order or structure of questions in the informal interview. The obvious advantage of this method lies in the fact that while certain topics are covered, there remains opportunity for the respondents to introduce issues which concern them.

The predetermined topics were concerned with the way in which nursing work is organised on the wards and the socialisation of the student nurse into the hospital culture. The interviews were undertaken with 40 student nurses at various stages of

COMMUNICATION IN NURSING—3

their training. The students were all volunteers and gave their time both generously and enthusiastically. This fact in itself enhanced the method, as the data collected were freely given. The researcher explained before the interview started that it was to be carried out in an informal conversational style; and that she was interested in what the students had to say on the subject, in general, not just on the issues raised by the researcher.

The point was emphasised that if the student wished to raise a topic which she considered to be relevant to the research area, she should feel free to do so; as free participation is the cornerstone of this method.

The method adopted draws heavily on the work of two American sociologists, Glaser and Strauss (1967). These researchers were interested in the events surrounding dying patients in American hospitals. They observed patients and staff and talked with them over a period of time and on the basis of the field notes, which they made during these observations, they developed what they called a 'grounded theory'. This notion of developing a theory which is grounded in the data was adopted for this present study.

Data

The theory which emerges should explain the data in a conceptual way, which enables those concerned with the area to make sense of the data and give them some insights into the subjects of study. Central to this method is the simultaneous collection and analysis of data. If the ideas of the respondents are to be allowed to direct the study it is necessary to analyse early data, in this case the interviews, in order to establish the main themes to follow up in later data collection.

In practice this meant that each of the 40 students was asked in a very open way to say what she thought was important in nursing.

The standard opening question was: 'I am interested in what nurses think about nursing. The kind of things I would like us to talk about, from your own experience so far, are what you think nursing is all about, what views you have on patient care, how nursing is organised—hospital life in general. Perhaps to start with, what matters most to you in nursing?, that is what do you think is really important in caring for patients.'

This meant that the interview followed the pattern set by the student. Yet as it progressed the researcher was able to introduce topics from the predetermined list where the student did not mention them spontaneously.

This mode of interview proved to be a successful way of eliciting the views of the student nurses; it was sufficiently informal to allow them to speak frankly yet had enough direction to be functional. The fact that the students were able to comment quite openly on a range of topics which they considered to be important is in itself evidence that the method merits serious consideration as a viable style of nursing research.



Exciting

The analysis and writing up of a study resulting from a qualitative approach has its difficulties. The early stages of the work tend to be exciting as ideas come thick and fast and the researcher is keen to move on to another interview in order to follow up or test out an idea from the last. At the end of the day, however, this set of themes and concepts has to be drawn together with the data and presented as a whole, which will convince its readers that here is, in fact, an adequate explanation of the substantive area under study.

As the tapes were played back and transcribed the ideas and themes which emerged began to fall into groups. This categorisation not only helped to order the data but also provided conceptual labels for the main themes in the data. These conceptual categories form the building blocks for the explanatory statements which the researcher must arrive at in order to explain the data.

It is not within the scope of this paper to elaborate any findings beyond the level required for illustration of the method; the description below serves to demonstrate category formation. The category described below emerged from interview data which were concerned with nurses talking to patients.

Nursing in the dark

This category emerged after several interviews in which students described the difficulties which they experienced concerning what they could say to patients. There is a wealth of nursing literature, particularly in the nursing press, which is devoted to communication. Nurses are being exhorted to talk with patients to explore their social circumstances, to nurse the whole patient and so on. During these interviews it became apparent that there are very real barriers to this style of nursing inherent in the way nursing is organised on the wards. The main factor which militates against nurses talking freely with patients is the way in which information is handled by the senior staff on the wards. The students frequently said that they did not know enough about the patients or indeed how much the patients knew about themselves; hence the idea of 'nursing in the dark' emerged.

Several students said that the ward report which they received at the start of a shift was inadequate. There is a tendency to be given a list of names, diagnoses and possibly some instructions about care. The latter nearly always related to the physical side of the care rather than an updating of how the patient was responding to and coping with his condition. Clearly, this state of affairs presented far more problems with some types of patients than others.

One student said: 'On some wards you don't even get a proper report on the patients—you don't feel safe to be let loose on them.'

Information

She said that the nurse in charge had the information but the ones who had to do all the basic work, namely, the students, are not told 'properly'; consequently: 'You don't know what to say to patients when they ask you things—just because you are not well enough informed about them.'

The same student said that it is extremely difficult if, as had happened to her, a patient says, 'I've got cancer' and the nurse herself didn't know the diagnosis because of the way information is handled on the ward.

As she said: 'The ward I'm on at the moment you might not get a report for

COMMUNICATION IN NURSING—3

six or seven days.'

One student expressed much the same difficulty when she said: 'Quite often you have to 'play ignorant', which is really bad if the patient has plucked up courage to speak to you.'

She thought that: 'It would be good if the information could be shared but the senior nurses hoard it.'

Lack of communication

This student was working on a radiotherapy ward and said that it was surprising how many people did not realise that radiotherapy is a treatment for cancer. The problem of lack of information among the students was, therefore, quite acute as they are constantly faced with patients who may or may not know their diagnosis.

Questioning of the students by these patients could be difficult because sometimes the student had no way of knowing whether the patient simply wanted to discuss what he already knew or if he was indeed seeking information about his diagnosis. Another student said that it is difficult to nurse patients if you have not managed to discover 'if he knows' before you approach him.

She said that the root of the problem was the lack of communication: 'Doctors and senior nurses never tell you.'

Yet another student said that she did not like patients asking her things because she felt ill equipped to answer them; 'On a lot of wards you are not told enough about the patient, the report is very quick.'

The overriding impression was one of student nurses being left in the uncomfortable position of being front line workers with barely enough information to work on. A common problem, apart from not knowing enough about the patient, was that the students often did not know what the patient had been told. Consequently the students have to develop strategies for coping with this information gap, strategies which often involve a guarded approach to nursing.

Qualitative research and nursing

The research approach finally adopted for the present study falls into the category of research methods which can broadly be described as qualitative methods. Qualitative method, or interpretive methods as they are sometimes called, place the emphasis on an understanding of the data from the perspective of the subjects of the research. This invariably means that there are few preconceptions at the outset of the research which has at its heart, the

constant interplay of data collection and analysis.

The quantitative methods, not least the social survey, have gained popularity with the advent of computer analysis. Findings can be put over in a scientifically respectable fashion, with the aid of sophisticated statistical analysis, which, along with larger sample sizes, have, in some instances, the added advantage of being generalisable to a wider population.



Researchers

The advantages of the quantitative approach to social research cause some researchers to dismiss any data and findings resulting from informal interviews and other qualitative approaches. Such data are dismissed on the assumption that they are too 'soft' and thus invalid.

Nursing has been studied from an operational research perspective, when the emphasis has been on who undertakes what tasks and for how long. Yet, there is an elusive element in nursing which cannot be observed; this element has to do with the caring aspect of the work. The unseen reasons for certain nursing actions, the almost instinctive parts of a nurse's role which are incorporated unwittingly into the nurse's work pattern; these are the areas of nursing which are amenable to a qualitative research approach.

Qualitative methods have much to offer in nursing research precisely because of this elusive element in

nursing which cannot be observed and quantified.

Wiseman (1974) likens the qualitative researcher to a detective in a classic murder mystery. 'Starting with few clues the detective questions persons connected with the case, develops hunches, questions further on the basis of those hunches, begins to see a picture of "what happened" start to emerge, looks for evidence pro and con, elaborating or modifying that picture—until finally the unknown is known.'

She contrasts the quantitative researcher in murder mystery terms when she says: 'The elements to be investigated are known—much as a murder where the *modus operandi* (MO) is known to the police. The structure provided by the MO or hypotheses allows for a preorganised investigation just as it does in survey research with precoded answers and set questions.'

It would seem that if nursing researchers were to take a long hard look at their methods they might find that the qualitative methods have great potential for nursing. A word of caution is provided by Zelditch (1962) when he argues that choice of research method is not an either/or affair. His concern is to obtain the best fit of research method and problem. This is particularly relevant in the diverse substantive area of nursing. Zelditch has the last word: 'There is a tendency to be either for or against quantification... To some extent the battle lines correlate with a relative concern for "hardness" versus "depth and reality" of data. Quantitative data are often thought of as "hard" and, qualitative "real and deep", thus if you prefer "real deep" data you are for qualitative participant observation. What to do if you prefer data that are real deep and hard is not immediately apparent.'

REFERENCES

- Glaser, B., Strauss, A. L. (1965). *Awareness of Dying*. Aldine Publishing Co, Chicago.
- Glaser, B., Strauss, A. L. (1967). *The Discovery of Grounded Theory*. Aldine Publishing Co, Chicago.
- Goddard, H. A. (1953). *The work of Nurses in Hospital wards*. Nuffield Provincial Hospital Trust, London.
- Moult, A., Hockey, L., Melia, K. M. (1978). Unpublished report for Leverhulme Trustees.
- Wiseman, J. P. (1979). The research web. In: *Social Research: Principles and Procedures*, Eds. Bynner, J., Stribley, K., 113-121. Longman/OU.
- Zelditch, M. (1979). Some methodological problems in field studies. In: *Social Research: Principles and Procedures*, Eds. Bynner, J., Stribley, K., 122-136. Longman/OU.

Ms Melia works at the Nursing Research Unit, University of Edinburgh

BIBLIOGRAPHY

- ABEL-SMITH, B (1960) A history of the nursing profession.
Heinemann : London
- ABRAHAMSON, M (1967) The professional in the organisation.
Rand McNally and Co. : Chicago
- ALEXANDER, M F (1980) Nurse education : an experiment in integration
of theory and practice in nursing. (2 vols.)
Unpublished PhD thesis : University of Edinburgh
- ALLEN, V L (1975) Social analysis. Longman : London
- ANDERSON, E R (1972) The role of the nurse - views of the patient,
doctor and nurse in some general hospitals in England.
Unpublished PhD thesis : Surrey University
- BAKER, D E (1978) Attitudes of nurses to the care of the elderly.
Unpublished PhD thesis : University of Manchester
- BECHHOFFER, F (1974) Current approaches to empirical research : some
central ideas in Rex, J (ed) (1974) Approaches to
sociology. Routledge and Kegan Paul : London
- BECKER, H S (1952) A note on interviewing tactics. Human
Organization 12 (4) 31-32
- BECKER, H S (1958) Problems of inference and proof in participant
observation. American Sociological Review 23,
652-60
- BECKER, H S (1962) The nature of a profession in Becker, H S (1970)
Sociological work - method and substance. Aldine :
Chicago
- BECKER, H S (1963) Outsiders. Free Press : New York
- BECKER, H S (1970) Sociological work - method and substance.
Aldine : Chicago
- BECKER, H S and GEER, B (1957) Participant observation and interviewing :
a comparison. Human Organisation 16 (3) 28-32
- BECKER, H S; GEER, B; HUGHES, E C and STRAUSS, A L (1961) Boys in
white. University of Chicago Press
- BENDALL, E (1974) The relationship between recall and application of
learning in trainee nurses. Unpublished PhD thesis :
London
- BENSMAN, J and GERVER, I (1963) Crime and punishment in the factory :
the function of deviancy in maintaining the social system.
American Sociological Review 38 (4) 488-98

- BIRCH, J (1975) To nurse or not to nurse. Royal College of Nursing : London
- BLAU, P M and SCOTT, W R (1963) Formal organisations : a comparative approach. Routledge and Kegan Paul : London
- BLAUNER, R (1964) Alienation and freedom. University of Chicago Press
- BLOOM, S W (1971) The medical school as a social system. Milbank Memorial Fund Quarterly 49 (2)
- BLOOM, S W (1973) Power and dissent in the medical school. Free Press : New York
- BLUMER, H (1939) An appraisal of Thomas and Znaniecki's 'The Polish Peasant in Europe and America'. Social Science Research Council : New York
- BLUMER, H (1962) Society as symbolic interaction in Rose A (ed) (1971, first published 1962) Human Behaviour and Social Processes. Routledge and Kegan Paul
- BLUMER, H (1969) Symbolic interactionism : perspective and method. Prentice Hall : Englewood Cliffs, N J
- BOGDAN, R and TAYLOR, S J (1975) Introduction to qualitative research methods : a phenomenological approach to the social sciences. John Wiley : New York
- BRAVERMAN, H (1974) Labor and monopoly capital - the degradation of work in the twentieth century. Monthly Review Press : New York
- BRUYN, S T (1966) The human perspective in sociology. Prentice Hall : Englewood Cliffs, N J
- BUCHER, R and STRAUSS, A L (1961) Professions in process. American Journal of Sociology 66, 325-334
- BULMER, M (1977) Sociological research methods - an introduction. Macmillan : London
- CARPENTER, M (1977) The new managerialism and professionalism in nursing in Stacey, M; Reid, M; Heath, C and Dingwall, R W J Health and the division of labour. Croom Helm : London
- CARR-SAUNDERS, A M and WILSON, P A (1933) The professions. The Clarendon Press : Oxford
- CICOUREL, A V (1964) Method and measurement in sociology. Free Press : New York
- CICOUREL, A V (1968) The social organization of juvenile justice. John Wiley : New York

- CICCOUREL, A V (1974) Theory and method in a study of Argentine fertility. John Wiley : New York
- CLARKE, M (1978) Getting through the work in Dingwall, R W J and McIntosh, J Readings in the Sociology of Nursing. Churchill Livingstone : Edinburgh
- COX, C and MEAD, A (eds) (1975) Sociology of medical practice. Collier MacMillan : London
- CRESSEY, D R (1950) Criminal violation of financial trust. American Sociological Review 15, 738-43
- CUFF, E C and PAYNE, G C F (eds) (1979) Perspectives in sociology. Allen and Unwin : London
- DAVIES, C (1976) Experience of dependency and control in work : the case of nurses. Journal of Advanced Nursing 1 (4) 273-282
- DAVIS, F (1960) Uncertainty in medical prognosis, clinical and functional. American Journal of Sociology 66, 41-47
- DAVIS, F (1975) Professional socialization as a subjective experience : the process of doctrinal conversion among student nurses, in Cox, C and Mead, A (1975) Sociology of medical practice. Collier MacMillan : London
- DENZIN, N K (1970) The research act in sociology. A theoretical introduction to sociological methods. Butterworths : London
- DENZIN, N K (1970) Sociological methods : a sourcebook. Butterworths : London
- DEPARTMENT OF HEALTH AND SOCIAL SECURITY (1972) Report of the Committee on Nursing (Cmd. 5115. Chairman: Briggs, A). HMSO : London
- DEPARTMENT OF HEALTH AND SOCIAL SECURITY (1979) Nurses, Midwives and Health Visitors Act 1979. HMSO : London
- DICKOFF, J and JAMES, P (1968) A theory of theories : a position paper. Nursing Research 17 (3) 197-203
- DINGWALL, R W J (1974) The social organisation of health visitor training. Unpublished PhD thesis : University of Aberdeen
- DINGWALL, R W J (1976) Accomplishing profession. Sociological Review 24 (2) 331-49

- DINGWALL, R W J (1977) The social organisation of health visitor training. Croom Helm : London
- DINGWALL, R W J and MCINTOSH, J (1978) Readings in the sociology of nursing. Churchill Livingstone : Edinburgh
- DINGWALL, R W J and LEWIS, P (eds) (in press). The sociology of the professions : lawyers, doctors and others. Macmillan : London
- DITTON, J (1977) Learning to "fiddle" the customers - an essay on the organised production of part-time theft. Sociology of Work and Occupations 4 (4) 427-50
- DODD, A (1974) Towards an understanding of nursing. Unpublished PhD thesis : University of London
- DRUCKER, P F (1954) The practice of management. Harper and Row : New York
- ETZIONI, A (1969) (ed) The semi-professions and their organization. Free Press : New York
- ETZIONI, A (1969) A sociological reader on complex organizations (2nd edition). Holt, Rinehart and Winston : New York
- FESTINGER, L and KATZ, D (1953) (eds) Research methods in the behavioural sciences. Staples Press : London
- FILSTEAD, W J (1970) (ed) Qualitative methodology : firsthand involvement with the social world. Markham : Chicago
- FLEXNER, A (1915) Is social work a profession? in Studies in Social Work 4. New York School of Philanthropy
- FREIDSON, E (1970a) Profession of medicine : a study of the sociology of applied knowledge. Dodd, Mead : New York
- FREIDSON, E (1970b) Professional dominance : the structure of medical care. Aldine : Chicago
- FROMM, E (1961) (trans. Bottomore, T) Marx's concept of man. Frederick Ungar : New York
- GARFINKEL, H (1967) Studies in ethnomethodology. Prentice Hall : Englewood Cliffs, N J
- GIDDENS, A (1974) Positivism and sociology. Heinemann : London
- GLASER, B (1978) Theoretical sensitivity advances in the methodology of grounded theory. Sociology Press : San Francisco
- GLASER, B and STRAUSS, A L (1965) Discovery of substantive theory : a basic strategy underlying qualitative research. American Behavioral Scientist 1965, 5-12
- GLASER, B and STRAUSS, A L (1965) Awareness of dying. Aldine : Chicago

- GLASER, B and STRAUSS, A L (1967) The discovery of grounded theory : strategies for qualitative research.
Aldine : Chicago
- GOFFMAN, E (1961) Encounters. Bobbs-Merrill : New York
- GOLD, R L (1958) Roles in sociological field observations.
Social Forces 36, 217-223
- GOUDSELOM, J (1977) Sociology in the balance - a critical essay.
Blackwell : Oxford
- HABENSTEIN, R W and CHRIST, E A (1955) Professionalizer, traditionalizer, utilizer. Columbia Press
- HALL, R H (1968) Professionalization and bureaucratization.
American Sociological Review 33, 92-104
- HARDIE, M (1980) Auxiliaries in nursing : implications for the division of labour. Unpublished PhD thesis :
University of Edinburgh
- HARDIE, M and HOCKEY, L (eds) (1978) Nursing auxiliaries in health care.
Croom Helm : London
- HENDERSON, V (1966) The nature of nursing. Collier MacMillan : London
- HOCKEY, L (1976) Women in nursing : a descriptive study.
Hodder and Stoughton : London
- HODGES, H A (1944) Wilhelm Dilthey, an introduction.
Routledge and Kegan Paul : London
- HUGHES, E C (1958) Men and their work. Free Press : New York
- HUGHES, E C; HUGHES, H M and DEUTSCHER, I (1958) Twenty thousand nurses tell their story. 'Lippincott : Philadelphia
- HUGHES, E C (1971) The sociological eye. Aldine : Chicago
- HUGHES, J A (1976) Sociological analysis : methods of discovery
Nelson : Middlesex
- HYMAN, H H (1954) Interviewing in social research.
University of Chicago Press
- INIÄN, U (1975) Towards a theory of nursing care.
Royal College of Nursing : London
- JOHNSON, M (1978) Big fleas have little fleas - nurse professionalisation and nursing auxiliaries in Hardie, M and Hockey, L (1978) (eds) Nursing auxiliaries in health care.
Croom Helm : London
- JOHNSON, T J (1972) Professions and power. Macmillan : London

- JUNKER, B (1952) Some suggestions for the design of field work learning experiences in Hughes, E C et al (1952) Cases in field work. University of Chicago
- KATZ, F E (1969) Nurses in Etzioni, A (1969) (ed) The semi-professions and their organisation. Free Press : New York
- KERLINGER, F (1964) Foundations of behavioural research. Holt, Rinehart and Winston : New York
- KING, I (1971) Towards a theory of nursing. John Wiley : New York
- KNAFL, K A and GRACE, H K (1978) Families across the life cycle. Little, Brown : Boston
- KOLAKOWSKI, L (1972) Positivist philosophy. Penguin Books : Harmondsworth
- KRATZ, C R (1978) Care of the long-term sick in the community. Churchill Livingstone : Edinburgh
- KRATZ, C R (1979) (ed) The nursing process. Balliere Tindall : London
- KRAUSZ, E and MILLER, S H (1974) Social research. Longmans : London
- LARSON, M S (1977) The rise of professionalism : a sociological analysis. University of California Press
- LAZERSFELD, P F and BARTON, A H (1951) Qualitative measurements in the social sciences in Lerner, D and Lasswell, H (1951) (eds) The policy sciences. Stanford University Press
- LAZERSFELD, P F (1972) Qualitative analysis : historical and critical essays. Allyn and Bacon : Boston
- LOFLAND, J (1971) Analyzing social settings. Wadsworth Publishing Co. : California
- LUPTON, T (1963) On the shop floor. Pergamon Press : Oxford
- MCCALL, G J and SIMMONS, J L (1969) (eds) Issues in participant observation : a text and a reader. Addison - Wesley : Cambridge, Mass
- MACCOBY, E and MACCOBY, N (1954) The interview : a tool of social science in Gardner, L (1954) (ed) Handbook of Social Psychology 1, 449-87
- McFARLANE, J K (1970) The proper study of the nurse. Royal College of Nursing : London
- McFARLANE, J K (1976) A charter for caring. Journal of Advanced Nursing 1, 187-196

- MACGUIRE, J M (1969) Threshold to nursing.
Occasional Papers on Social Administration 30,
C. Bell & Son : London
- McINTOSH, J (1977) Communication and awareness in a cancer ward.
Croom Helm : London
- MACINTYRE, S (1977) Single and pregnant. Croom Helm : London
- MATZA, D (1969) Becoming deviant. Prentice Hall : Englewood Cliffs, N J
- MAUKSCH, H O (1966) The organizational context of nursing practice
in Davis, F (ed) The nursing profession - five
sociological essays. John Wiley : London
- MEAD, G H (ed. Morris, C) (1934) Mind, self and society.
University of Chicago Press
- MECHANIC, D (1968) Medical sociology. Free Press : New York
- MELTZER, B N (1964) Mead's social psychology in Manis, J G and
Meltzer, B N (1972) Symbolic interaction : a reader in
social psychology (2nd edition).
Allyn and Bacon : Boston
- MENZIES, I (1960) A case study in the functioning of social systems
as a defence against anxiety. Tavistock : London
- MERCER, G M (1979) The employment of nurses. Croom Helm : London
- MERTON, R K (1957) Social theory and social structure (revised edition).
Free Press : New York
- MERTON, R K et al (1957) The student physician.
Harvard University Press : Cambridge, Mass
- MILLERSON, G (1964) The qualifying associations : a study in
professionalization. Routledge and Kegan Paul : London
- MINISTRY OF HEALTH, SCOTTISH HOME AND HEALTH DEPARTMENT (1966)
Report of the Committee on Senior Nursing Staff Structure.
(Chairman: Salmon, Brian). HMSO : London
- MOULT, A; HOCKEY, L and MELIA, K M (1978) Patterns of ward
organisation. Unpublished report for Leverhulme Trustees
- NEWBY, H (1979, first published 1977) The deferential worker.
Penguin Books : Harmondsworth
- NIE, N H; HULL, C H; STEINBRENNER, K and BENT, D H (1975)
Statistical Package for the Social Sciences (2nd edition)
McGraw Hill : New York

- NUFFIELD PROVINCIAL HOSPITALS TRUST (1953) (Goddard)
The work of nurses in hospital wards.
Nuffield : London
- OLESEN, V and WHITAKER, E (1968) The silent dialogue : a study of the social psychology of professional socialisation.
Jossey Bass : San Francisco
- OREN, D E (1971) Nursing : concepts of practice.
McGraw Hill : New York
- PAPE, R (1964) Touristry : a type of occupational mobility.
Social Problems 11, 336-44
- PARK, E and BURGESS, E W (1921) Introduction to the science of sociology. University of Chicago Press
- PEMBREY, S E M (1978) The role of the ward sister in the management of nursing : a study of the organisation of nursing on an individual patient basis. Unpublished PhD thesis : University of Edinburgh
- PILL, R (1970) The sociological aspects of the case study sample in Stacey, M; Dearden, R; Pill, R and Robinson, D (1970) Hospitals, children and their families.
Routledge and Kegan Paul : London
- POMERANZ, R (1973) The lady apprentices : a study of transition in nurse training. Occasional Paper on Social Administration 51,
Bell : London
- PSATHAS, G (1968) The fate of idealism in nursing school.
Journal of Health and Social Behaviour 9, 52-64
- PSATHAS, G (1968) The student nurse in the diploma school of nursing.
Springer : New York
- REX, J (1961) Key problems of sociological theory.
Routledge and Kegan Paul : London
- RICHARDSON, S; DOHRENWEND, B S and KLEIN, D (1965) Interviewing : its forms and functions. Basic Books : New York
- ROBINSON, W S (1951) The logical structure of analytic induction.
American Sociological Review 16, 812-18
- ROCK, P (1979) The making of symbolic interactionism.
Macmillan : London
- ROETHLISBERGER and DICKSON (1939) Management and the worker.
Harvard University Press : Cambridge, Mass
- ROSE, A (1962) (ed) Human behaviour and social processes.
Routledge and Kegan Paul : London

- ROY, C (1974) Conceptual models for nursing practice.
Appleton Century Crofts : New York
- ROY, D (1952) Quota restriction and gold bricking in a machine shop.
American Journal of Sociology 57, 427-42
- ROY, D (1954) Efficiency and the fix.
American Journal of Sociology 60, 255-66
- RUSSELL, B (1927) Philosophy. Norton : New York
- SCHATZMAN, L and STRAUSS, A L (1973) Field research : strategies for a natural sociology. Prentice Hall : Englewood Cliffs, N J
- SCHLOTTFELDT, R (1975) The need for a conceptual framework in
Verhonick, L L (1975) Nursing Research I.
Little, Brown : Boston
- SCOTT, W R (1969) Professional employees in a bureaucratic structure :
social work in Etzioni, A (1969) (ed) The semi-professions and their organization. Free Press : New York
- SCOTT, W R (1966) Professionals in bureaucracies : areas of conflict,
in Vollmer, H and Mills, D (1966) (eds) Professionalization.
Prentice Hall : Englewood Cliffs, N J
- SELLTIZ, C et al (1957) Research methods in social relations.
Methuen : London
- SHAW, C (1930) The Jack roller. University of Chicago Press
- SHAW, C (1931) The natural history of a delinquent career.
University of Chicago Press
- SHORTELL, S M (1974) Occupational prestige differences within the
medical and allied health professions. Social Science and Medicine 8, 1-9
- SIMPSON, I H (1979) From student to nurse : a longitudinal study of socialisation. Cambridge University Press
- SJOBERG, G and NETT, R (1968) A methodology for social research.
Harper and Row : London
- SKIDMORE, W (1979) Theoretical thinking in sociology (2nd edition).
Cambridge University Press
- STINCHCOMBE, A L (1959) Bureaucratic and craft administration of
production : a comparative study.
Administrative Science Quarterly 4, 168-187
- STOUTER, S A (1949) The American soldier. Princeton University Press

- STRAUSS, A (1956) George Herbert Mead on social psychology.
University of Chicago Press
- STRAUSS, A; SCHATZMAN, L; EERLICH, D; BUCHER, R and SABSHIN, M (1963)
The hospital and its negotiated order in
Freidson, E (1963) (ed) The hospital in modern society.
Free Press : New York
- STRONG, P and DAVIS, A G (1977) Roles, role formats and medical
encounters : a cross-cultural analysis of staff-client
relationships in children's clinics.
Sociological Review 25 (4) 775-800
- STRONG, P M (1979) The ceremonial order of the clinic : parents,
doctors and medical bureaucracies.
Routledge and Kegan Paul : London
- THOMAS, W I and ZNANIECKI, F (1918-20) The Polish peasant in Europe
and America. University of Chicago Press
- THRASHER, F (1928) The gang. University of Chicago Press
- TOWELL, D (1975) Understanding psychiatric nursing.
Royal College of Nursing : London
- TROW, M (1957) Comment on participant observation and interviewing :
a comparison. Human Organization 16 (3) 33
- VOLLMER, H W and MILLS, D J (1966) (eds) Professionalization.
Prentice Hall : Englewood Cliffs, N J
- WEBER, M (1947) (trans. Henderson and Parsons) The theory of social and
economic organization. William Hodge : London
- WEBER, M (1922) (trans. Roth and Wittich 1968) Economy and society.
Bedminster Press : New York
- WHYTE, W F (1955) Street corner society (2nd edition).
University of Chicago Press
- WILLER, D (1967) Scientific sociology.
Prentice Hall : Englewood Cliffs, N J
- WILLIAMS, C A (1979) The nature and development of conceptual
frameworks in Downs, F S and Fleming, J W (1979)
Issues in nursing research. Appleton Century Crofts :
New York
- WOLFF, K H (1950) The sociology of Georg Simmel.
Free Press : New York
- YOUNG, M (1971) (ed) Knowledge and control. Collier MacMillan : London

ZNANIECKI, F (1934) The method of sociology.
Farrer and Rinehart : New York

ZORBAUGH, H (1929) Gold Coast and the slum.
University of Chicago Press